SUPPORTING ACCESS TO BREASTMILK THROUGH WET NURSING IN EMERGENCIES

Technical and operational guidance for emergency preparedness and response

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IFE CORE GROUP

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CONTENTS

ACRONYMS

BMS	Breastmilk substitute
CMAMI	Community management of at-risk mothers and infants under 6 months of age
DHMB	Donor human milk bank
HIV	Human immunodeficiency virus
IFE Core Group	Infant Feeding in Emergencies Core Group
IYCF	Infant and young child feeding
IYCF-E	Infant and young child feeding in emergencies
MHPSS	Mental health and psychosocial support
OG-IFE	Operational Guidance on Infant and Young Child Feeding in Emergencies
UNICEF	United Nations Children's Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

Breastfeeding offers the healthiest start in life. It promotes cognitive development, provides essential nutrients and life-saving immunity against diseases, and offers long-term benefits for maternal and child health. Breastfeeding reduces the burden of childhood and maternal illness, lowering health care costs and creating healthier families. When women breastfeed, everyone benefits. Yet, in 2023, less than half (48 per cent) of infants under 6 months of age globally were exclusively breastfed. While this is a notable increase from 37 per cent in 2012, further progress is essential to meet global targets and save more lives. Across the world, there are nearly 600,000 child deaths each year attributable to infants not being breastfed as recommended, many of these result from diarrhoea and pneumonia.[1] During emergencies, the life-saving protection of breastfeeding is of greater importance. Across all emergency contexts, infants and young children are particularly vulnerable, especially regarding their feeding and nutrition. Breastfeeding offers protection against these risks by providing a safe, nutritious and accessible food source, as well as hydration, comfort, connection and protection against disease. Investing in policies and programmes that protect, promote and support breastfeeding is a crucial element of emergency preparedness. Communities with strong breastfeeding practices and knowledge are better prepared to maintain nutrition security for infants during emergencies.

The Infant Feeding in Emergencies Core Group's *Operational Guidance on Infant and Young Child Feeding in Emergencies* (OG-IFE 2017) states that if an infant is not breastfed by his or her mother, the priority is to explore feeding options that enable access to breastmilk. Options include relactation, wet nursing and donor human milk. If these options are not acceptable or feasible, access to a reliable supply of an appropriate breastmilk substitute (BMS), accompanied by essential support, should be enabled as a last resort.

Wet nursing is the practice of a woman breastfeeding an infant other than her own. This guidance focuses on wet nursing as a compassionate act of charity following an emergency or personal crisis, describing it as a consensual, unpaid arrangement between an infant's caregiver(s) and a woman willing to breastfeed the infant. Wet nursing is recognized by the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the IFE Core Group, and the Sphere Standards, and is endorsed by the World Health Assembly as a recommended infant feeding option.

Wet nursing has a long and mixed global history, involving a wide range of practices, experiences and outcomes. Despite declining in some settings, wet nursing remains valued and supported by cultural and religious beliefs in many countries. Emergency responders should be aware that wet nursing occurs in most communities worldwide and may become more prevalent during emergencies, and they should be prepared to respond appropriately. At a minimum, responders should avoid interfering with or discouraging existing practices unless there are compelling reasons against wet nursing in a specific situation.

In every emergency, it is necessary to assess and act to protect and support the nutrition needs and care of both breastfed and non-breastfed infants and young children. Compared with other feeding options, wet nursing support has often been overlooked within emergency preparedness and response plans due to a lack of guidance on how to support it. To address this gap, this technical and operational guidance provides practical advice on why, where, when and how to support wet nursing within health and nutrition emergency response programmes.

Wet nursing should be considered within preparedness and early needs assessment, alongside other globally recommended infant feeding alternatives. This involves a critical analysis of the current acceptability, feasibility, and relative risks of each available option given the specific emergency context and an assessment of any needs for wet nursing support within the emergency-affected community.

Informed by contextual analysis and assessment of feasibility and acceptability, policy-makers and decision-makers need to determine the extent to which wet nursing will be actively protected, promoted and supported in a given context. Support can include facilitating informed decision-making, identification and screening of wet nurses, risk mitigation and service referrals, as well as counselling to help get wet nursing off to a good start and enable breastfeeding continuation.

The steps described in this guidance for identifying a wet nurse and for supporting the establishment, continuation and eventual cessation of wet nursing are universally applicable, designed to be adapted to meet diverse emergency response needs and contexts. Once wet nursing has been identified as the preferred infant feeding method, a wet nurse needs to be found. While

the ideal is to identify an already lactating woman who can meet an infant's immediate nutritional needs, the robustness and flexibility of lactation allow for expanding the pool of potential wet nurses to include women who are willing to relactate or induce lactation. Basic criteria for wet nurses include the requirement that a wet nurse is in good overall mental and physical health, with adequate nutrition status, willing and motivated, accepted by the infant's caregivers/and supported by her own family to breastfeed someone else's infant.

Even in an emergency setting where laboratory testing for infectious diseases is not feasible, safeguarding steps can still be taken to screen wet nurses and reduce risks. The detection of any issues during screening does not automatically mean that wet nursing is precluded. Rather, knowledge can inform decision making and risk mitigation measures. Programme implementers should ensure appropriately trained health care professionals and community-based breastfeeding counsellors are available to provide breastfeeding support. These counsellors play a vital role in facilitating initiation of wet nursing, providing ongoing support to sustain the arrangement, and assisting in the ending of wet nursing when it is no longer required.

Governments are responsible for developing, implementing, monitoring, and evaluating national policies and programmes on infant and young child feeding (IYCF), including in emergencies, and other maternal, newborn and child health related interventions, depending on the context. The inclusion of wet nursing support within national and subnational emergency preparedness and response plans requires clear and coherent policies and guidelines, as well as adequate resources and political commitment. Such policies, and their related strategies, guidelines and action plans, should include appropriate options for wet nursing and related practices where the practice is acceptable and feasible to implement.

BACKGROUND

Rationale for the development of this guidance

Throughout history, women have wet nursed to ensure the survival of infants who could not be breastfed by their mothers.[2] The WHO and UNICEF (2003) Global Strategy for Infant and Young Child Feeding and subsequent global guidance, including the OG-IFE, recommend wet nursing as one of the feeding options for infants who cannot be breastfed by their mothers.

It is estimated that over 300 million people around the world need humanitarian assistance and protection due to conflicts, climate emergencies, infectious disease outbreaks, economic factors and other drivers.[3] In these emergencies, breastfeeding is lifesaving, yet maternal breastfeeding may be threatened. As evidenced by UNICEF and WHO, breastmilk substitute companies leverage crises to market their products, making donations, undermining breastfeeding and jeopardizing the health and nutrition of infants and young children.[4] Untargeted distributions of BMS during emergencies results in preventable food insecurity, malnutrition, morbidity and mortality in infants and young children.[5] The emotional distress, physical exhaustion, lack of space and privacy, disruption to services and lack of breastfeeding support commonly experienced by mothers in emergencies can result in early cessation of breastfeeding. As emergencies become more frequent and severe, the ability to support life-saving breastfeeding practices, including wet nursing, is increasingly vital for those involved in the care and protection of infants, young children and their caregivers.

Despite the potential for wet nursing to protect vulnerable infants during emergencies, support for wet nursing is often overlooked in emergency preparedness and response plans and national guidelines and policies. This was highlighted during the COVID-19 pandemic, when WHO recommendations for wet nursing were rarely included in national guidelines.[6] [7] To date, the absence of specific guidance on wet nursing has impeded support for the practice, particularly in emergencies.[8] [9] [10] Currently, in-depth global guidance on infant feeding focusses on supporting infants breastfed by their mothers and non-breastfed infants fed with BMS, although the latter is an infant feeding method that is supposed to be supported only as a last resort.[11] [12] To safeguard the health and survival of infants in emergencies, UNICEF and the IFE Core Group identified the need for guidance to support practitioners in facilitating international recommendations on wet nursing in contexts where this practice is acceptable.

Scope and purpose

This guidance provides technical and practical advice on why, where, when and how to support wet nursing within health and nutrition programmes. It is primarily intended to guide emergency response but is also applicable in non-emergency settings to enhance resilience and preparedness. It aims to systematically facilitate access to breastfeeding for vulnerable infants by normalizing support for wet nursing as part of IYCF or infant and young child feeding in emergencies (IYCF-E) strategies alongside breastfeeding counselling and other recommended practices, such as relactation and use of donor human milk.[13]

Wet nursing can be supported both at-scale and at the individual level, and it can be both privately arranged or initiated and facilitated by service providers. Recognizing the diverse reasons for wet nursing, this guidance focuses on situations typically encountered in emergencies within which wet nursing can be considered urgent and important for child survival. As defined in Box 1.2, it covers wet nursing as an altruistic practice, not as a commercial occupation. While expressed donor human milk is recognized as a recommended infant feeding alternative, this document only addresses its use within the context of wet nursing.

Audience

This guidance is intended for those involved in providing care and support for infants, young children and their families during emergency preparedness and response, including policy-makers and decision-makers, donors, programme planners and managers working with governments, United Nations agencies, lactation professional associations, mother-to-mother breastfeeding support associations, non-governmental organizations and other organizations responding to emergencies. This guidance is also expected to inform and raise awareness among colleagues from sectors other than nutrition (such as health and child protection), who work closely with emergency-affected communities for the protection and betterment of children.

Development process

This guidance was informed by interviews with 23 key informants, three case studies and a literature review of more than 80 publications on wet nursing and related practices in emergency and non-emergency settings. It draws upon guidance on human milk banking and informal milk sharing, noting their differences from wet nursing. The IFE Core Group Technical Advisory Group was closely involved in content development and review, with further expertise sought as required.

A rapid evidence review was conducted, focusing on narrative and systematic reviews, as well as a separate desk review and expert consultation on terminology. The need for a more robust evidence review is acknowledged.

Limitations of the guidance include the exclusive use of English for research, and the predominance of Western perspectives and histories in identified literature. To address this, practitioners from diverse cultures, including Indigenous communities, actively participated in the process as Technical Advisory Group members and key informants. Given how deeply rooted infant feeding practices are within religious beliefs and sociocultural contexts, UNICEF acknowledges the need to complement this guidance with thorough local consultation and further research.[14]

How to use this guidance

For a comprehensive understanding, sequential reading from Chapter 1 onwards is recommended. Information relevant to the roles of different actors in emergency preparedness and response is organized as follows:

- IYCF counsellors and other frontline workers: Chapters 3 and 4
- Programme planners and managers: Chapters 2, 3 and 4
- **Policy-makers** and other decision-makers: Chapter 5

Boxes offer additional explanations and guidance for deeper understanding of certain topics. **Spotlights** illustrate key points with real-world examples. **Case studies** document programming experiences and practical insights on wet nursing. Readers are encouraged to consider applicability within their context. **Footnotes** contain explanatory details and signposts to further resources, such as tools and further guidance.

This guidance should be implemented within a broader context of protection, promotion and support for breastfeeding, in accordance with complementary global guidance and guidelines. In particular, it should be read and applied in conjunction with the following:

- Implementation Guidance on Counselling to Improve Breastfeeding Practices – which provides global guidance for implementing the recommendations outlined in the WHO Guideline: Counselling of Women to Improve Breastfeeding Practices,[15] ensuring that all women receive high quality breastfeeding counselling, with appropriately trained staff, in a sufficient number of contacts, and in a manner and mode most appropriate for their local context.
- Operational Guidance on Breastfeeding Counselling in Emergencies – a pragmatic guide that covers key considerations and potential adaptations when applying the Guideline: counselling of women to improve breastfeeding practices.
- Operational Guidance on Infant and Young Child Feeding in Emergencies – provides concise, practical guidance on how to ensure appropriate IYCF in emergencies.
- Operational Guidance on HIV and Infant Feeding in Emergencies – intended to be used to complement emergency and sectoral guidelines on health, nutrition and HIV, including specifically: infant feeding, prevention of mother-to-child transmission of HIV and paediatric antiretroviral treatment.

CHAPTER 1

INTRODUCTION

A. Introduction to infant and young child feeding in emergencies

During emergencies (*see Annex A, Definitions*), infants and young children are vulnerable, especially regarding their feeding and nutrition. The younger the child, the more at risk they are. This applies across all emergency settings, including middle-income and high-income countries. About half of all deaths of children under the age of 5 years, particularly under 1 year, are related to malnutrition.[16] Breastfeeding offers protection against many of the most significant risks posed to children in emergencies, while artificial feeding aggravates them.[17] The importance of breastfeeding for children, women, families and wider society is well-documented, as are the risks of not breastfeeding and of feeding any BMS. Non-breastfed infants are a highly vulnerable risk group requiring intensive protection and support during emergencies.[18]

Breastfeeding is particularly vital during emergencies given the often limited access to safe water, hygiene and sanitation; the increased risk of disease and food insecurity; the lack of access to health care; and difficulties in obtaining and hygienically using BMS. Given these benefits, breastmilk is the most secure food source for infants in emergency situations. Communities with strong breastfeeding practices and knowledge are better equipped to maintain infant nutrition security during emergencies and require fewer external resources during emergency response and recovery.[19] Knowledge of wet nursing, and other such empowering practices, enables community members to help each other collectively safeguard infant survival, health and well-being during crises.

However, breastfeeding can be challenging during emergencies. A mother's well-being may decline, impairing her ability to responsively breastfeed her infant, which can increase her risk of breastfeeding difficulties and potentially lead to a gradual decline in milk supply. As required by international standards of care, skilled breastfeeding support should be prioritized to help maintain confidence, overcome challenges and enable successful breastfeeding, alongside referrals for additional support, as required. Although the goal is for infants to be breastfed by their own mothers, the reality is that sufficient support is not always immediately available or accessible. This can lead to a rise in the number of infants who are not (fully) breastfed by their mothers. These infants need immediate access to breastmilk from another source or, as a last resort, hygienically-prepared BMS.[20] The number of infants without access to their own mothers' milk may also rise for other reasons, including increases in temporary or permanent separation of mother and baby due to maternal death, illness, injury, detention or displacement.[21]

Some infants will have been fed with BMS before an emergency; however, during emergencies, BMS becomes riskier to use. This dramatic change in risk profile makes the need for safer alternatives more pressing. Older children who have stopped breastfeeding may also benefit from returning to breastmilk as a survival food in emergency contexts where there is food insecurity. As noted during the COVID-19 pandemic, appreciation among mothers of the protective effects of breastfeeding for their infants during infectious disease outbreaks could prompt increased interest in relactation and a return to exclusive breastfeeding.

Special programmes are often needed during emergencies to address such specific situations, facilitate alternative infant feeding solutions and save lives.[22] This need is particularly acute in contexts where the use of BMS was common pre-emergency, including those in middle-income and high-income countries.[23]

Box 1.1: Recommended IYCF practices

1. **Breastfed within the first hour of life.**

2. **Exclusively breastfed for the first six months of life**, meaning that the infant receives only breastmilk (from his or her mother or a wet nurse) or expressed breastmilk, and any necessary medicines. No other liquids or solids are provided, including water.

3. **Breastfed until 2 years of age or beyond**, alongside the introduction of nutritionally adequate and safe complementary foods at 6 months of age.

4. **Breastfed frequently and responsively**, which involves noticing and responding to a child's cues for hunger, fullness and need for comfort, both during the day and night.

Discussing these recommendations with caregivers and wet nurses early on in recruitment and counselling processes can help manage expectations and inform practical arrangements.

B. Introduction to wet nursing

Wet nursing is the practice of a woman directly breastfeeding another woman's infant or young child.[i]

For the purposes of this guidance, wet nursing refers to a consensual unwaged breastfeeding arrangement between an infant's caregiver(s) and a woman willing to breastfeed the infant. It focuses on wet nursing as a compassionate act of charity following a personal crisis or local/humanitarian emergency.[24] It is important to be aware that there are different interpretations of the term wet nursing and some controversy surrounding its use (*see Box 1.2*).

When a wet-nursed infant's mother also breastfeeds the child, this practice is known as cross feeding.[ii] Related human milk exchange practices include the use of ***informal donor human milk*** (known as *informal milk sharing or expressed breastmilk sharing*) and ***formal donor human milk*** available through *human milk banks* (*see Annex A, Definitions*). **Within this guidance, the general term donor human milk includes both informal and formal donor human milk.**

Box 1.2: A note of caution on language

This guidance uses *wet nursing* as the standard English term that is used within WHO and UNICEF documents and widely recognized.

However, it is important to be aware of potential language sensitivities and misunderstandings in diverse cultural contexts. In some settings, *wet nursing* is understood as a commercial arrangement, involving payment.[25] It can also carry negative connotations related to colonialism, racism, slavery, exploitation, coercion and the commercialization of breastfeeding, making its use inappropriate in some settings. In some cultures, wet nursing implies additional caregiving responsibilities beyond breastfeeding. Cultures without a wet nursing tradition may not have a specific term for the practice, while others use different terms to describe the practice of breastfeeding another woman's infant.[26] In languages other than English, wet nurses are often known as *milk mothers* (such as *madre de leche* in Spanish, 奶妈 in Chinese and *ibu susuan* in Bahasa Indonesia). Other terms for wet nursing include *non-maternal breastfeeding, allomaternal breastfeeding* and *at-the-breast milk sharing.* Examples of terms that describe the breastfeeding of an infant that one did not give birth to, and which may be used in specific situations, include *adoptive breastfeeding, co-feeding, grandmother breastfeeding* and *foster breastfeeding (see Annex B).*

It is important to consult with communities and check which terminology is understood and accepted. Neutral, local terms that imply mutual consent and dignity are preferred. If no suitable local terms exist, descriptive language can be used instead, as demonstrated throughout this guidance.

At an individual level, align with basic counselling principles by actively listening and adopting the language used by the person being supported.[27]

i Wet nursing is often defined as the *breastfeeding of an infant by someone who is not the infant's biological mother*. However, such definitions may be insensitive to certain breastfeeding relationships, such as adoptive breastfeeding. Adoptive mothers may not identify as wet nurses. The omission of the term *biological* is therefore preferred when using this definition.

ii Also known as *shared breastfeeding* and *cross nursing*. *See Annex B.*

BRIEF HISTORY OF WET NURSING

Wet nursing has a long and varied global history that is important for those involved in IYCF-E to be aware of. This knowledge enables effective, ethical and culturally sensitive interventions, informed by past lessons and an understanding of how historical events influence current attitudes and practices.

Wet nursing is not a new practice. From the start of human history until today, women have provided their breastmilk in various ways.[28] [29] Nutrition and growth during the most vulnerable early stages of life depended on breastmilk, either from the infant's mother or another lactating woman.[30]

Various kinds of wet nursing practices have existed in human cultures and religions. Wet nursing has a history of its own in each human civilization, with variations in practice leading to vastly different experiences and outcomes. While wet nursing frequently occurred in populations with high maternal mortality, it also occurred for social, cultural, political, religious and economic reasons.[31] For example, it was used to establish lasting connections between two groups of people, similar to the bonds of blood. Known as milk kinship, this practice of creating family bonds through breastfeeding was adopted by various religions and cultures around the world but is most widely known within Islamic law and Muslim cultures, where it still exists (*see Box 1.4*). Religious texts such as the Bible, the Torah and Islamic scripture all describe women wet nursing and, if appropriate, can be referenced to help build trust and acceptance.

In some cultures, wet nursing was institutionalized and professionalized. For some women, wet nursing was a well-compensated and respected profession. For example, Ancient Egyptian art showed wet nurses as worshipped figures or saviours. In cultures spanning the Middle East and North Africa, wet nurses were often treated as part of the infant's family, offered gifts, and cared for in their older age.

Accounts from various cultures describe the practice of women breastfeeding infants whose mothers have died, reflecting community spirit and a collective responsibility to care for children. Beyond life-saving nutrition alone, Indigenous cultures worldwide have long recognized shared breastfeeding as a way to strengthen communities. Breastfeeding practices between neighbours, friends and community members have played an important role in shaping women's social networks, distributing domestic labour, building community relationships, and improving their overall well-being. For example, reports from South Africa describe how Zulu and Bantu grandmothers began lactating as a result of breastfeeding their grandchildren for comfort.

Historically, however, wet nursing has also been implemented as a coercive and exploitative practice, particularly when wet nursing became widespread in societies with social differences based on wealth and power. A key highly problematic example of exploitative wet nursing is found in the history of the United States during the era of race-based slavery. Enslaved mothers were often forcibly separated from their breastfed infants in order to live with and breastfeed their slave owner's children. This came at a high cost to their own infants' health and survival, as their babies were often prematurely and abruptly weaned and fed inadequate substitutes (such as animal milks, gruel or porridge) unless other women could breastfeed them.[32] Forced wet nursing in the context of slavery also occurred in other locations.[33] [34]

Box 1.3: Key takeaways from the history of wet nursing

- **Wet nursing is not new.** Recognizing its historical roots can foster trust with communities.
- **There is diversity in wet nursing practices and experiences.** Responders should consider the cultural and historical significance of wet nursing in a given context to guide more effective interventions.
- **There may be sensitivities around wet nursing.** Being aware of historical experiences and traumas ensures that aid workers engage communities with empathy and respect, using context-specific approaches.
- **Ethical, sociocultural, and economic considerations** need to be carefully weighed, even and especially in emergencies.
- **Health considerations/barriers** There may be misconceptions, suspicions or health concerns about wet nursing and the use of shared breastmilk. These can be addressed in counselling with caregivers and communities.

There is a long history of suspicion of breastmilk. Sharing breastmilk, whether through wet nursing or expressing, was especially discouraged in the twentieth century. This was due to the misconception that breastmilk was similar to other bodily fluids and therefore dangerous and potentially contaminated. These fears increased at the start of the HIV pandemic in the 1980s. Although it was later proven that not breastfeeding was more dangerous than HIV in many countries, recommendations were hastily adopted for HIV-positive mothers to practice replacement feeding with BMS despite a

lack of evidence.[35] This had severe and long-lasting consequences, as it resulted in many unnecessary deaths and changed infant feeding practices for both HIV-positive and HIV-negative mothers, even in communities that previously had a strong breastfeeding culture.

Understanding of the mixed and diverse history of wet nursing will assist emergency responders, programmers, and policy-makers to provide culturally sensitive, ethical, and appropriate wet nursing interventions during emergencies.[36]

SITUATIONS IN WHICH WET NURSING MAY OCCUR

The need for wet nursing can vary from temporary to long-term. The mother may be absent or present, and wet nursing can occur spontaneously or be planned.

Wet nursing occurs for many different reasons (*see Case Study 1A: Impact of breastfeeding a medically fragile foster child; and Box 3.4: Motivations for wet nursing).* This guidance focuses mainly on situations commonly found during emergencies, within which wet nursing can be considered urgent and important for child survival. These include situations where the infant's mother is unavailable (such as maternal death, separation, abandonment and exceptional instances of severe maternal illness or injury) and cases involving a small number of maternal medical conditions and medications for which maternal breastfeeding is contraindicated.[37] Cross feeding can be used to supplement a mother's milk in cases of confirmed milk insufficiency, and to support women to manage breastfeeding problems or to restart or increase their milk production *(see Case Study 3B for an example of increasing supply, from Bangladesh).*

At the individual level, the situations in which wet nursing is considered acceptable will depend on personal values, cultural norms and religious beliefs. Check with the infant's caregivers whether their personal situation is considered an acceptable reason for wet nursing, keeping in mind that acceptability often increases during emergencies.

CURRENT WET NURSING PRACTICES

It is well-documented that women breastfeed or express breastmilk for other women's infants globally *(see Spotlight 1A as an example).*[38] Despite declining in some settings, wet nursing continues to be valued and supported by cultural and religious beliefs in many countries.[39, 40] A 2014 analysis of 104 cultures showed that 93 per cent practiced wet nursing and other forms of non-maternal breastfeeding to varying extents, with it being the norm in six cultures (*see Spotlight 1B).*[41, iii]

Wet nursing is most common in communities with high infant and maternal mortality and morbidity rates, cultures of cooperative mothering and where breastfeeding is highly valued and seen as a collective responsibility.[42, 43, 44, 45] Wet nursing can also be more common within sub-groups, such as certain Indigenous groups and local breastfeeding support groups.[46]

Spotlight 1A: Cross feeding traditions in Northern India[47]

A study highlighted family and community traditions of cross feeding by sharing the account of a woman who grew up in a traditional Muslim family in northern India. It was considered shameful to allow an infant to cry when someone was available to provide comfort and breastmilk. As an infant, the woman had been breastfed by various family members, and as an adult, she continued the tradition of cross feeding with her neighbour, a close friend, and her husband's first wife, with whom she shared the breastfeeding of their five children into toddlerhood.

Spotlight 1B: Normative wet nursing among the Aka tribe in Congo Basin[48]

Among the Aka hunter-gatherer tribe, cross feeding is common, extensive sharing of food and childcare is a core value, responsive caregiving is practised, and infants are frequently breastfed. A study observing 20 Aka infants showed that 60 per cent participated in non-maternal nutritive and non-nutritive suckling. On average, these infants were breastfed 15–25 per cent of the time by a tribe member other than their mother. The practice of wet nursing has been found to also be normative; that is, regular, frequently observed, or not unusual, in five other hunter-gatherer tribes, including the Agta, Bofi, Efe, Chabu, and Onge.

While restrictions on wet nursing exist in some cultures, it is rare for the practice to be forbidden under all circumstances.[49] Even where it appears to be uncommon, it is usually still accepted.[50,51,iv] However, in many high-income countries, wet nursing has been largely replaced by BMS and human milk banking, and has become unfamiliar to many caregivers, health workers and

iii The study by Hewlett and Winn (2014) surveyed 258 cultures across the globe, sourced from the eHRAF (Human Relations Area Files), and found 104 cultures with data on the practice of women other than the mother breastfeeding infants. The analysis indicated that breastfeeding by women other than the child's mother occurs in most cultures (93.3 per cent). It was found to be normative in six cultures with data, while seven cultures have cultural beliefs and sanctions against it.

iv Research from Türkiye illustrates that even where wet nursing is less common, women can still be willing to help with breastfeeding; while only 8.7 per cent (n = 20) of 240 surveyed women had previously acted as a wet nurse, 80.9 per cent were willing to wet nurse if necessary (Ergin, 2018). A recent study of 1,050 Ghanaian women found that while only 8 per cent reported ever sharing breastmilk informally, despite high breastfeeding rates (81 per cent breastfed their children), around 60 per cent reported they would not be concerned about doing so (Obeng, 2022).

governments.[52] The HIV pandemic and uncertainty around managing breastfeeding in the context of HIV has also contributed to a decline in wet nursing practice.

Globally, wet nursing is most likely to be practised and accepted as a compassionate response to a personal crisis, such as maternal separation, illness or death (*see Spotlight 1C*).[53] Such crises happen more often during humanitarian emergencies, when BMS can be more difficult to obtain and riskier to use, and when access to formal donor human milk may also be disrupted. Emergencies therefore often prompt increases in relactation, wet nursing, and informal milk sharing (*see Case Study 1A*).[54, 55, 56] Caregivers might be more open to wet nursing if the arrangement is made through an organization, such as NGOs working in emergency response programmes related to IYCF-E.[57]

During emergencies, the focus on saving lives and caring for vulnerable infants may lead to the easing of customary and religious norms that discourage wet nursing. Emergency responders should therefore not prematurely dismiss wet nursing; rather, they should first understand the cultural context and the impact the emergency may have on its acceptability. It is also important to respect the diversity *within* cultures and religions by enabling individuals to make their own decisions from available feeding options. Emergency responders can play an important role in normalizing wet nursing and assisting those engaging in or considering the practice. Guided by evidence-based infant feeding recommendations, they can and should make explicit recommendations about the best course of action to support caregivers with decision-making, especially in circumstances where the risk of infant death is very high.[58]

Spotlight 1C: Wet nursing during personal crises

Australia:59 A Martu grandmother in her thirties, already breastfeeding her own infant, began breastfeeding her granddaughter when her daughter suffered a breast infection and had experienced difficulty breastfeeding. She continued breastfeeding until her daughter recovered.

Central Africa:60 In the Bofi community, when a mother of a one-year-old passed away, a female elder took over the breastfeeding duties, ensuring the infant's survival.

Indonesia:61 In Sulawesi, Toradja tradition mandates finding a breastfeeding woman in the village or nearby surroundings to breastfeed a child if the child's mother dies in childbirth or cannot feed her child.

Syrian Arab Republic:62 In the aftermath of a 2023 earthquake, a newborn was found alive under the rubble, with her deceased mother. The local hospital manager's wife took on the care and breastfeeding of the orphaned infant alongside the breastfeeding of their four-month-old daughter.

United States of America:63 More than 20 mothers formed a roster to breastfeed or express breastmilk for an infant whose mother had died. One of them said: *"It is a valuable gift for everyone involved. It has taught us the importance of family, community and sharing."*

United Kingdom:64 A hospitalized mother of twins sought donor milk via Facebook after running out of expressed breastmilk, prompting a nearby lactating woman to visit the hospital and act as a wet nurse. The same woman also shared breastfeeding duties with friends for more than six months for a child whose mother was undergoing breast cancer treatment.

Spotlight 1D: Shifting attitudes: The rise of wet nursing and informal milk sharing during the war in Ukraine[65]

Prior to the war in 2022, interest in wet nursing and informal milk sharing was reportedly low in Ukraine. Initial concerns about the high prevalence of HIV and the lack of cultural acceptability of these practices led to their exclusion from early guidelines on IYCF-E developed by international responders. However, cases of wet nursing and informal milk sharing were reported in situations of necessity, such as in shelters and occupied territories without access to breastfeeding support or BMS. In other instances, misguided safety concerns prevented these potentially life-saving practices. Online platforms were developed to facilitate connections between lactating women willing to assist and infants in need. One notable example occurred in besieged Mariupol, where mothers not only breastfed their own children but also breastfed and expressed breastmilk for many others, including older children. Viewed as a critical source of nutrition and food security for children in the area, wet nurses were highly valued and protected by their community. This experience highlights the possible shift in attitudes and practices under emergency conditions and underscores the importance of preparing emergency responders to confidently provide reassurance and appropriate guidance on wet nursing and informal milk sharing to caregivers.

Box 1.4: Wet nursing and milk kinship in Islam

Milk kinship, the creation of permanent family bonds through breastmilk, is widely recognized within Islamic religious belief and culture.[66] [67] Traditionally, it served to expand one's network of relatives to rely on for assistance and cooperation.[68] In Islamic law, milk kinship (Al Rida') has important implications for family law.[69] A man must never marry his milk siblings and blood relatives.[70] [71] [72] During emergencies affecting Muslim communities, emergency responders often view Islamic milk kinship as a reason for not exploring or encouraging wet nursing (arkan al rada), leading to its omission from emergency response plans. Such assumptions should be avoided and efforts made to understand the community's culture and context-specific beliefs.

Cultural and contextual variations

How wet nursing and milk kinship are practised varies and is influenced by cultural and contextual factors. The conditions required to establish milk kinship, such as the number of feedings and feeding mode, differ across Islamic schools of thought (madhhabs).[73] [74] [75]

Islam's recognition of wet nursing familiarizes Muslim communities with the practice, and Islamic beliefs and value systems can support it.[76] [77] [78] The Qur'an specifically approves of wet nursing as a means to fulfill children's right to be breastfed, provided both parents consent, and recognizes a wet nurse's right to compensation unless she voluntarily declines. Wet nursing is understood to be rewarded in the afterlife and the Prophet Muhammad was wet nursed himself, which can also support its acceptance, particularly when reinforced through faith-based counselling.[79] [80]

In Islamic law, adopted children are not automatically considered mahram (kin with whom marriage is forbidden).[81] This means that, as the children grow older, they must maintain certain boundaries regarding modesty and interactions with family members of the opposite sex, including avoiding physical contact. However, breastfeeding has the power to change the adopted child's status. If the conditions to establish milk kinship are met, the child is then considered kin by breastmilk, enabling interactions with adoptive family members similar to those permitted with biological relatives.

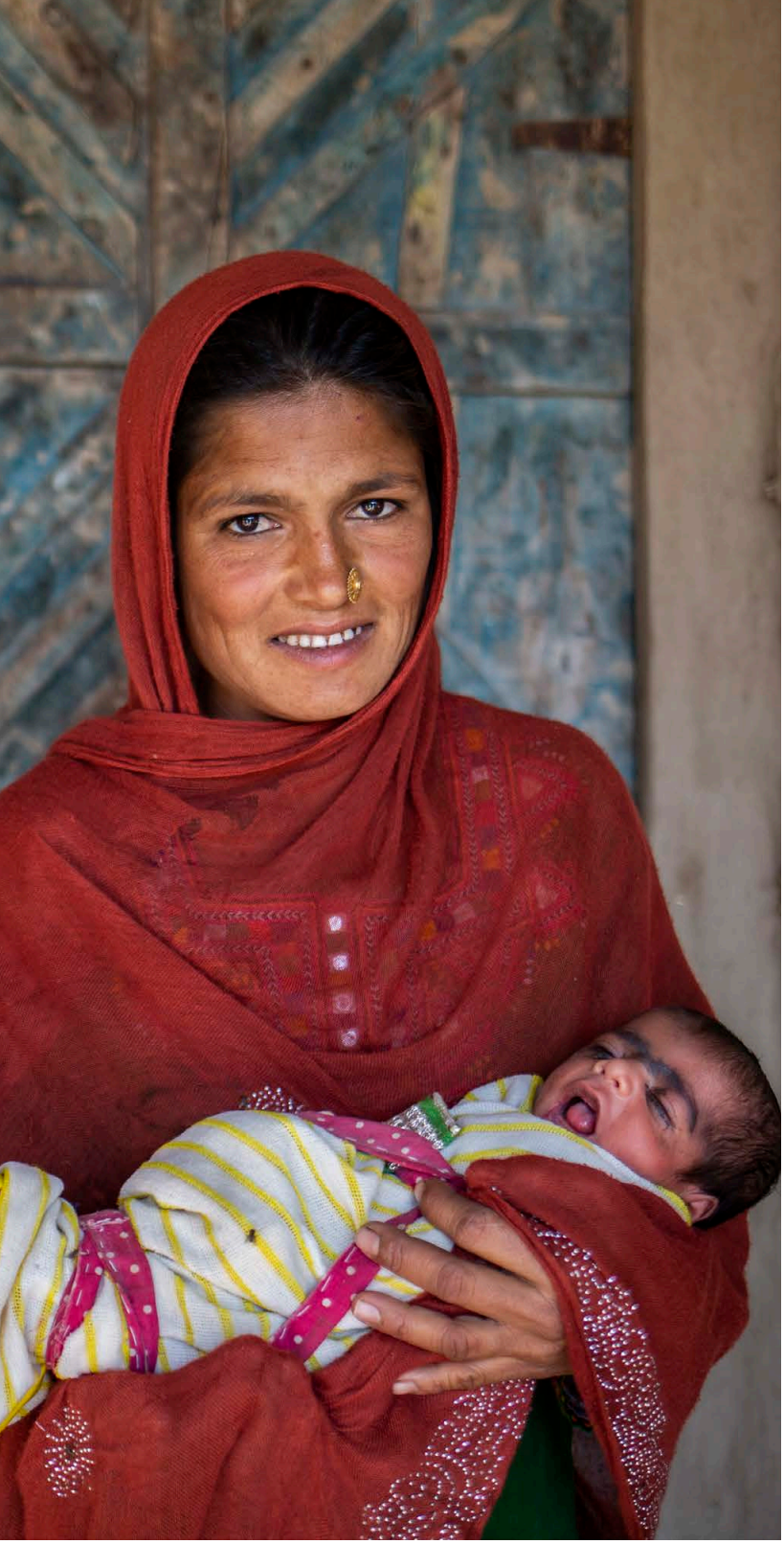
However, the degree of acceptability varies and in some Muslim settings wet nursing and milk sharing is only accepted in exceptional circumstances. For example, interdisciplinary research between the UK and Malaysia revealed such exceptions may include medical emergencies.[82] Islamic teachings on compassion, mercy,

the preservation of human life, and mutual help become especially relevant during emergencies, and usual practices and decisions may be adjusted if a situation is urgent and critical. It is therefore important for emergency responders to consult women, decision-makers within families (such as husbands, mothers-in-law and/or other elderly relatives) and religious leaders to understand current cultural and contextual acceptability, including any conditions that must be met.

Experiences from human milk banking

Research on human milk banking highlights the compatibility of human milk sharing practices with Islamic milk kinship, provided respect and attention are given to Islamic beliefs. For example, in some Islamic traditions, milk kinship is considered to be created even if the identity of the woman who provided the milk is unknown and for this reason, anonymous milk donation is forbidden whenever the conditions for establishing kinship are met, as it may result in improper marriage.[83] Milk banking involving unknown donors and pooled milk is therefore not acceptable where this understanding applies.[84] However, religious considerations can be taken into account through innovations, such as single known donor, screening, documentation of the milk kinship relationship and/or introduction of milk donor and recipient .[v, 85, 86, 87]

v Islam is particular in the selection of a wet nurse. The characteristics of an ideal wet nurse include being healthy, religious, good-natured, and living a healthy lifestyle without alcohol or drugs, among other desirable traits.



GUIDANCE FOR POLICY-MAKERS, DECISION-MAKERS

An awareness of the local understandings of Islamic milk kinship should inform wet nursing programming and may also be of relevance to other sectors, such as child protection *(see Case Study 2B for an example of how creation of milk kinship can support orphans).* Programmatic adaptations should be considered, such as providing documentation of the milk kinship relationship in accordance with Islamic law *(see Case Study 2A),* in addition to offering person-centred, culturally sensitive counselling and care. Practitioners have found that concerns can often be alleviated through effective counselling that addresses religious requirements.[vi] Counsellors need to be willing to understand families' beliefs and discuss what wet nursing means for them, helping them make informed decisions. Emergency responders must be aware of milk kinship laws to prevent legal or ethical issues for the children and families involved. Collaboration with community and religious leaders is key to understanding norms, gaining acceptance, ensuring feasibility and compliance, building trust, identifying suitable wet nurses and addressing practical challenges. While milk kinship can complicate wet nursing programming, the strong religious and often also cultural support for breastfeeding and wet nursing within Islamic cultures can also help to facilitate it.

Box 1.5: Summary of history and current practices

Wet nursing is a long-standing and well-established practice.

There is a lot of diversity within and between cultures:

- In most cultures, it is practised (uncommon but accepted).
- In very few cultures, it is common practice.
- In very few cultures, cultural beliefs strongly discourage it.

Emergencies and personal crises are situations during which wet nursing is more practised and may be accepted in cultures where it is usually discouraged.

vi In addition to the standard counselling topics to cover in early conversations, topics covered during culturally sensitive counselling of individuals who wish to respect Islamic milk kinship principles may include the implications of wet nursing on Islamic rulings, Islamic requirements for selecting a wet nurse, and documentation accepted by the Islamic court of law.

IMPORTANCE OF WET NURSING IN EMERGENCIES

Comparative analysis of feeding options: Benefits and risks for the infant

Wet nursing provides life-saving protection, connection and nurturing care to infants. A rapid literature review, with a focus on reviewing existing narrative or systematic reviews, found that in almost all situations all forms of breastmilk feeding are safer than BMS. Specifically, wet nursing is a safer and more beneficial option than BMS, especially in emergencies where the importance of the protection of breastfeeding is heightened and the risks associated with BMS use are greater.

Operational relevance and feasibility of wet nursing as an option during emergencies

In any emergency, there will be infants who are not being breastfed. In situations where an infant is not being breastfed by their mother, relactation is a recommended option. However, relactation will not feed the infant immediately. Relactation and feeding with a mother's expressed breastmilk are not viable solutions in cases where the mother is absent. This means that alone, there are not adequate solutions for ensuring that all non-breastfed infants get the nutrition they need during emergencies. As such, planning for alternative feeding for non-breastfed infants, including wet nursing, is necessary.[88]

This section highlights the operational relevance and feasibility of wet nursing as a valuable feeding option in emergencies and clarifies why, in some emergency contexts, it may be the only feasible option for feeding infants at the onset of an emergency.

- **Rapid response:** Wet nursing can be initiated immediately, making it invaluable at the onset of acute emergencies when quick solutions are critical.
- **Widespread accessibility:** Wet nursing can be accessed and practised anywhere. It is available across all communities, including in hard-to-reach areas, which ensures that even the most isolated infants can benefit during crises.
- **Locally driven solution:** Wet nursing relies on local knowledge and practices, making it a naturally localized response in emergencies. It can be initiated without external assistance, especially in cultures with a tradition of wet nursing.
- **Family and community-based:** Wet nursing leverages existing social structures and family networks, which can maintain continuity when other systems are disrupted or inoperative.
- **No complex logistics:** Unlike some other feeding options, wet nursing does not require supply chain management for sourcing, transporting and storing goods, nor does it depend on cold chains or waste management systems, given there is no risk of expiry, excess, spoilage or inappropriate donations.[89]
- **Minimal hygiene requirements:** The direct mouth-to-nipple breastfeeding mechanism eliminates the risk of extrinsic contamination that exists for all other feeding alternatives to varying degrees, removing the need for hygienic preparation protocols, cleaning and sterilization of feeding equipment or maintaining clean preparation and storage spaces.[90]
- **No special facilities or intensive management requirements:** Wet nursing operates independently; it does not require the specialized facilities or distribution and monitoring systems needed for human milk banking operations or BMS programming, which are costly to run and can face significant operational and accessibility challenges in emergencies.[91]
- **Reduced contamination and safety risks:** Direct breastfeeding avoids the complexities and potential risks associated with handling and processing donor human milk or preparing BMS in emergencies.[92] Problems such as incorrect reconstitution or inadequate screening and processing, bacterial growth and spoilage are avoided.
- **Regulatory compliance and do no harm:** Wet nursing promotes breastfeeding and avoids concerns related to promotion of BMS and violations of the International Code of Marketing of Breast-milk Substitutes.

This risk-benefit analysis makes it clear that wet nursing must be thoroughly considered within emergency preparedness and response plans and appropriately and adequately supported at programmatic level. It is crucial to ensure access to as many acceptable feeding options as possible to accommodate variability in individual circumstances, needs and risk tolerance, with wet nursing included as a key option.

Case Study 1A: Impact of breastfeeding a medically fragile foster child [93]

A 'medically fragile child' requires intensive, specialized care due to his or her medical condition(s). High dependence on specialized nutritional and/or medical services for survival and development renders such children highly vulnerable in emergencies. The multifaceted potential benefits of wet nursing for medically fragile and/or emotionally distressed infants are highlighted here. This case report describes the foster breastfeeding of "Anne" *(see Annex B)*, who was placed in foster care in the United States at three-weeks old.

Case introduction

Anne was born too small and too soon (1.9 kg at 35 weeks) with multiple chronic health conditions and neonatal abstinence syndrome (i.e., withdrawal from drugs). Drug-affected infants such as Anne are often highly agitated and uncomfortable; she constantly cried when awake and slept very little. She experienced extreme pain after feeding and had constipation requiring medication. Numerous attempts to alleviate these feeding difficulties by switching her infant formula failed. At 3 months of age, Anne weighed just 2.7 kg and was classified as "failure to thrive". Her survival was uncertain.

Initiating foster breastfeeding

Anne's foster mother, experienced in breastfeeding five of her own children, intuited that breastfeeding could benefit Anne. Upon obtaining approval from child welfare authorities, she began putting Anne to the breast for comfort, day and night. Using the Supplementary Suckling Technique, Anne was initially supplemented with infant formula and later with formal donor human milk. The Supplementary Suckling Technique, alongside other supportive measures, enabled gradual relactation. By the time Anne was 9 months old, her foster mother was producing enough milk to fully breastfeed her. This approach provided essential nutrients and comfort, addressing both Anne's nutritional and emotional needs through breastfeeding.

Foster breastfeeding outcomes

The act of suckling immediately soothed Anne's distress, providing pain relief and supporting her to fall asleep. However, switching from infant formula to donor human milk marked the true turning point for Anne. The provision of breastmilk enabled spontaneous stooling, longer sleep periods and improved overall health and growth. Anne stopped screaming after feeding confirming that the extreme pain Anne had been suffering was due to a formula intolerance. Relieving an infant's pain is critical, not only out of compassion but because chronic pain can disrupt caregiver-child relationships, increasing the child's risk of developing an insecure attachment.

At the time of documenting Anne's case, she had reached 25 months of age and weighed 9.1 kg. She continued to breastfeed without any health crises since switching to breastmilk. This marked improvement transformed the attitudes of Anne's health care providers and social workers from scepticism about breastfeeding's value to advocacy for the provision of breastmilk to medically vulnerable infants in foster care.

Conclusion: situations in which wet nursing may be especially impactful

This case study highlights the potential for wet nursing to meet both the nutritional and emotional needs of medically fragile infants, making a compelling case for its inclusion in IYCF-E strategies. It identifies several situations, particularly prevalent during emergencies, where wet nursing and/or informal milk sharing may be particularly beneficial, including for:

- **Medically fragile infants –** Given the known protective and therapeutic effects of breastmilk, provision to all medically fragile infants who cannot be breastfed by their mothers is desirable. It is particularly relevant for infants who have medical conditions for which BMS are contraindicated, and in emergency settings where access to specialized care may be limited. Breastmilk remains available as a potentially life-saving resource, particularly when it is fed directly at the breast and is therefore biologically tailored to meet that child's individual needs.
- **Infants with traumatic histories –** The impact of breastfeeding may be especially significant for infants who have experienced early relational trauma, such as separation from their birth mother, or exposure to abuse or neglect.[94] Breastfeeding mechanisms, such as skin-to-skin contact, rhythmic rocking, and nurturing gazes are key in enhancing neurodevelopment and strengthening an infant's ability to develop secure attachments, providing essential feelings of safety, trust and belonging. Breastfeeding also strengthens the capacity of the caregiver for sensitive, responsive caregiving, which is especially valuable in cases in which a child is challenging to care for.[95]
- **Infants who are in foster care or adopted –** During emergencies, the rise in maternal deaths and displacement may increase the number of children being cared for by relatives or others. As demonstrated here, foster/adoptive breastfeeding may benefit such infants. Infants who have lost their mothers (especially those in institutional care) may experience *failure to thrive*, linked with deprivation of nurturing touch.[96] Breastfeeding provides frequent, intimate, skin-to-skin contact to counteract this. Wet nursing by relatives or foster carers may be especially important for abandoned or motherless infants. It is particularly appropriate in cases in which (1) the child is likely to be in long-term care, (2) the child has been previously breastfed or (3) the child's mother expresses a desire for the infant be breastfed by another person, potentially while maintaining her own milk supply in anticipation of reunification. There are implications for policy, suggesting the need for frameworks that facilitate breastfeeding, when appropriate, within caregiving arrangements such as foster care.

C. International recommendations and standards

Wet nursing is supported by numerous international guidance. The WHO 2004 **Guiding principles for feeding infants and young children during emergencies** states, *"every effort should be made to identify alternative ways to breastfeed infants whose biological mothers are unavailable. These children, as well as those who have never been breastfed, should still have breast milk in their diets if at all possible. To meet their needs, relactation and, if culturally acceptable, wet nursing, should be actively promoted, especially for infants under six months of age."*

The IFE Core Group's **Operational Guidance on Infant and Young Child Feeding in Emergencies** (OG-IFE 2017) directs emergency responders to intervene to protect and support infants and children who are not breastfed by their mothers to meet nutritional needs and minimize risk. Point 5.11 of the guidance states:

"Where an infant is not breastfed by [his or her] mother, quickly explore, in priority order, the viability of relactation, wet nursing and donor human milk, informed by cultural context, current acceptability to mothers and service availability."[97]

The directive to support wet nursing during emergencies is further echoed in the **Sphere Minimum Standards for Humanitarian Action** (IYCF standard 4.2) and within the **WHO and UNICEF 2018 Operational Guidance on HIV and Infant Feeding in Emergencies**.[98] The WHO publication **Relactation: A review of experience and recommendations for practice** specifically describes relactation in the context of wet nursing in emergencies.[99] During the recent COVID-19 pandemic, WHO recommended wet nursing as an alternative feeding method for infants whose mothers were confirmed or suspected to have COVID-19 and could not breastfeed them (e.g., due to severe illness), noting that wet nurses should be prioritized for the youngest infants.[100]

If milk from the infant's mother is not available, wet nursing is strongly recommended by WHO within the management of severe wasting and/or nutritional oedema in infants who are less than 6 months of age.[101] WHO guidelines for preterm and low birthweight infants currently do not include recommendations on wet nursing and unpasteurized donor human milk.[102] However, due to the heightened importance of breastmilk and the increased risks of using BMS for this vulnerable group, especially during emergencies, it can be assumed that these options may be preferred over BMS if pasteurized donor human milk from a human milk bank is unavailable.

Box 1.6: Summary of recommended alternative feeding methods

For infants not receiving their own mother's breastmilk directly, the OG-IFE and other key global guidance recommend exploring feeding alternatives in the following order to ensure the best nutrition and safety outcomes:

1. **Relactation**: Support the mother to breastfeed her infant directly again. This process may be facilitated by cross feeding to temporarily supplement the infant *(see Annex B)*.
2. **Wet nursing or feeding with donor human milk**:
   a. **Wet nursing**: Identify and request a healthy lactating woman to act as a wet nurse *(see Chapter 3)*. This may include full wet nursing or cross feeding (in situations where the infant's mother is present but unable to produce enough milk to fully meet the infant's nutritional needs).
   b. **Donor human milk**: Source donor human milk either from a human milk bank or by identifying and requesting a healthy, lactating woman to express breastmilk for the infant. Feed the expressed milk to the infant using a cup, spoon or – in hygienic medical settings – nasogastric tube.
3. **Using a breastmilk substitute**: As a last resort, explore using an appropriate BMS, such as ready-to-use infant formula or powdered infant formula. To avoid the risks associated with bottle feeding, ensure it is fed by cup, spoon or – in hygienic medical settings – by nasogastric tube if indicated.

These methods should be carefully considered, taking into account acceptability, feasibility, affordability, sustainability and safety in emergency settings and the infant's specific situation, with full participation in decision-making by the infant's caregiver.

CHAPTER 2

PLANNING, IMPLEMENTING AND MONITORING WET NURSING INTERVENTIONS

GUIDANCE FOR PROGRAMMERS AND DECISION-MAKERS

A. Assessment and context analysis[vii]

In every emergency, it is necessary to assess and act to protect and support the nutrition needs and care of both breastfed and non-breastfed infants and young children. Compared to other interventions, wet nursing support may be overlooked due to a lack of planning and adequate background information.[103] It is therefore critical that wet nursing is considered in emergency preparedness and as part of early needs assessment. This includes an assessment and critical analysis of its **feasibility** and **acceptability**, as well as any **needs for support**, as detailed below.

ASSESS THE NEED FOR WET NURSING SUPPORT AND UNDERSTAND THE CONTEXT

As highlighted in Chapter 1, emergencies often increase the need for alternative infant feeding solutions, such as wet nursing, for infants who cannot be breastfed or are not being fully breastfed by their mothers.[104] To assess the need for wet nursing support, the following priority actions should be undertaken:

1. **Monitor for alerts in early needs assessment:** Investigate signs indicating that wet nursing may be needed, such as reports of maternal deaths, reports of non-breastfed infants under 6 months of age, infants under 6 months of age with wasting, or high rates of pre-crisis artificial feeding.[viii]

vii For guidance on conducting IYCF-E needs assessments, see: Technical Rapid Response Team (2016) Fact sheet on Infant and young child feeding practices assessment in emergencies and OG-IFE (2017) Section 4.

viii For a complete list of alerts, see: OG-IFE Section 4.10

2. **Determine IYCF practices and estimate the number of non-breastfed infants:** This will inform the scale of support required for such infants, noting that support may include IYCF counselling, skilled support for relactation, wet nursing, donor human milk, and (as a last resort), artificial feeding, depending on cultural acceptability and feasibility.
3. **Assess safety, feasibility and acceptability:** Evaluate the current safety, feasibility and cultural acceptability of feeding options for non-breastfed infants, including wet nursing, donor human milk and BMS.[105] Consider the relative risks and benefits of these alternatives in the specific emergency context. Further guidance on wet nursing is detailed below.

Priority actions 2 and 3 involve reviewing pre-crisis data, considering their relevance to the current emergency context, and subsequently conducting needs assessments using appropriate methods to address identified information gaps.[106] Further information can be gathered using more in-depth assessment methods later in the emergency to refine the understanding of needs and response design. Factors to consider assessing are listed in Box 2.1.

ASSESS THE CURRENT ACCEPTABILITY AND FEASIBILITY OF WET NURSING

As per OG-IFE 5.13, the cultural acceptability of wet nursing and the availability of wet nurses should be investigated in preparedness, and rapidly re-examined as part of early needs assessment. If available, pre-crisis IYCF data may assist. However, the prevalence of wet nursing is often unknown or under-reported pre-crisis.[ix]

Pre-crisis data on general breastfeeding knowledge, attitudes and practices and the policy environment may also assist.

Emergencies change the relative risks and feasibility of various infant feeding methods including wet nursing, which may subsequently change acceptability. Therefore, re-evaluating these factors in consultation with the emergency-affected community is essential for informed decision-making about programming.[107 x]

Box 2.1: What to assess to inform decision-making and programming for wet nursing

Considerations for determining the acceptability and feasibility of wet nursing, the need for support, and the scale, scope, and urgency of any required support, include:

- **Number of non-breastfed and partially breastfed infants**
- **Safety, acceptability and feasibility of alternative infant feeding options**
- **Cultural acceptability of wet nursing**
- **Motivations for wet nursing (see Box 3.4)**

Practical feasibility of wet nursing – Mobility and accessibility for wet nurses and caregivers, considering geographic spread, transportation, safety and security, and movement restrictions, as well as overall feasibility of breastfeeding (i.e., conditions that support women to breastfeed)

Availability of wet nurses – Women's health status and overall well-being (in relation to the basic eligibility criteria for wet nurses), time availability given their other responsibilities, willingness and motivation, opportunities for familial support, and the impact of displacement patterns on availability

Gender-related considerations – Presence of any constraints related to women's health status and overall well-being, their time use/availability, safety and security risks (including exposure to gender-based violence), decision-making power, and possibility of exploitation or coercion

Infectious disease environment – Current prevalence of infectious disease, including any outbreaks of infectious diseases with implications for breastfeeding.

Community capacity and emergency impact – Pre-existing community familiarity and pre-crisis prevalence of wet nursing, impact of the emergency on the community's ability to support and facilitate wet nursing (e.g. related to disruption of community networks)

Barriers and enablers – Individual, sociocultural and structural factors that constrain wet nursing, and potential solutions and opportunities

Response capacity[xi] – National or subnational IYCF-E response capacity in terms of policies, plans and guidelines, human resources and organizational capacity, coordination, information management, IYCF-E service delivery, financial capacity, community and advocacy, as well as the capacity of required support services

Operational environment – Humanitarian access to the affected population, mobility, and geographical location

ix This is due to several factors, including its omission in pre-crisis population surveys and standard emergency needs assessments and stigma leading to non-disclosure.

x If artificial feeding was prevalent pre-crisis and has become much riskier due to an emergency, the acceptability of wet nursing should be re-assessed if it is initially found to be low, following community sensitization and education.

xi For further guidance on assessing IYCF-E capacity, see: UNICEF, Save the Children, Global Nutrition Cluster (2022) IYCF-E Capacity Assessment Tool and Guidance < Infant and Young Child Feeding in Emergencies (IYCF-E) Capacity Mapping and Assessment Toolkit | Global Nutrition Cluster .

Focus group discussions and key informant interviews can be conducted to understand cultural norms and beliefs surrounding wet nursing in the affected population, noting that acceptability and willingness to engage in wet nursing will vary at an individual level. Key groups to consult include women, especially mothers and other primary caregivers, as well as religious[xii] and community leaders, health and nutrition workers, and other influencers and decision-makers in the community. Possible questions are suggested in Box 2.2. Decision-makers responsible for IYCF-E programming should avoid dismissing wet nursing (based on assumptions that it is unacceptable or unfeasible) without proper community consultation.[108]

Box 2.2: Examples of assessment questions for community consultation

- What and how were babies who could not be breastfed by their mothers fed before the emergency?
- What and how are babies who cannot be breastfed by their own mothers currently fed? Why are they fed this way?
- What feeding options are currently available for these babies?
- Who can breastfeed someone else's baby (relationship to infant and characteristics)?
- What is the term for breastfeeding someone else's baby within your culture and language?
- What is the main cultural or religious influence on wet nursing practices in your community?
- In which situations or for which reasons can someone breastfeed someone else's baby?
- Why might someone choose to practice, or not practice, wet nursing?
- How can women in the community be protected and supported to breastfeed someone else's baby?
- Is anything usually given to women in exchange for breastfeeding someone else's baby? For example, are gifts, money or non-monetary support expected? Has this changed in any way because of the emergency?
- Within your community, who normally decides how babies are fed? And who influences these decisions?

Questions should be adapted according to appropriate local terminology *and* asked using appropriate methods that are sensitive to any stigma, safety or privacy concerns related to wet nursing.[109]

B. CAPACITY STRENGTHENING

PROVIDERS OF SKILLED SUPPORT FOR WET NURSING DURING EMERGENCIES

Breastfeeding support and counselling are crucial during emergencies and should be provided by a continuum of appropriately trained health care professionals and community-based breastfeeding counsellors. Breastfeeding counsellors play a vital role in supporting both caregivers of non-breastfed infants and wet nurses.[xiii]

In certain contexts, access to sustained skilled support has been shown to be a key factor for ensuring the success of wet nursing programmes.[110] Support can include facilitating informed decision-making, identification and screening of wet nurses, risk mitigation and service referrals, as well as assisting with initiating wet nursing and enabling its continuation by offering ongoing assistance to overcome any difficulties. Peer breastfeeding counsellors in particular play an important role in fostering acceptance and confidence in wet nursing within their communities, and can be powerful agents for protecting and reclaiming any traditional wet nursing knowledge and customs. Indigenous people should be provided with a supportive environment in which to share knowledge of cooperative breastfeeding customs and practices.

COUNSELLING COMPETENCIES TO SUPPORT WET NURSING

Anyone with a solid foundation in basic breastfeeding/infant feeding counselling competencies, such as listening and learning, providing empathy, building confidence[xiv] and managing common breastfeeding challenges, can play an important role in ensuring the success of wet nursing.[xv] Supporting wet nursing in emergencies does not require highly specialized or advanced skills.

Actions for *assisting a woman to breastfeed someone else's infant* are detailed in this chapter. To effectively do so, counsellors require confidence in the safety and feasibility of wet nursing, underpinned by an understanding of the protective properties of breastmilk, how breastfeeding works, and the flexibility of lactation including that it is possible to breastfeed multiple children and to relactate or induce lactation. Counsellors who normally work in non-emergency settings may be aware of, but may have limited practical experience with, supporting wet nursing.[111]

xii There may be diversity in how religious scriptures and directives are interpreted during exceptional circumstances, such as emergencies (*see Box 1.4* on Islam as an example).

xiii For further guidance on identifying providers, refer to: IFE Core Group, Operational Guidance: Breastfeeding Counselling in Emergencies – Chapter 5, Section 5.1: Providers of Breastfeeding Counselling (2021).

xiv Building caregivers' and wet nurses' confidence has been found to be important in contributing to a positive experience for women who are willing to act as wet nurses (Azad et al., 2019).

xv For an overview of basic and advanced competencies for emergencies, refer to: IFE Core Group, Operational Guidance: Breastfeeding Counselling in Emergencies – Chapter 5, Section 5.2 Counselling Competencies (2021).

As a first step, counsellors responding to an emergency should be equipped with the **basic counselling competencies** listed in the *Operational Guidance: Breastfeeding Counselling in Emergencies.* In situations where adequate IYCF counselling capacity has not yet been established, at minimum, frontline workers should not intervene in or discourage wet nursing that is already occurring within the emergency-affected community, unless serious risks (e.g., related to child protection) are clearly present or evidence-based policies and guidelines recommend against it in a specific context *(see Chapter 5: Policy).*

C. PROGRAMMING

SUPPORT IDENTIFICATION AND RECRUITMENT

IYCF-E programmes can play an important role in scaling up the identification and recruitment of potential wet nurses by:

- Providing **physical spaces** with skilled staff where women and their children can regularly gather (supportive spaces for IYCF-E, such as Mother Baby Areas or Nurturing Care Centers).[xvi] This can help create interpersonal connections, thereby strengthening the potential wet nurse's familiarity, trust and motivation to wet nurse infants in need.
- Promoting and coordinating wet nursing and the sharing of expressed breastmilk when needed within **health and nutrition services,** including in postnatal wards and stabilization centres.
- Supporting and overseeing new or existing[xvii] peer-to-peer online platforms.[112]
- At facility or community level, collecting, securely storing and regularly updating basic information on women in the local area who are willing to breastfeed someone else's infant. The information should be regularly updated to ensure registered individuals are still willing and able to provide breastfeeding assistance, and to add new potential wet nurses.
- Recruiting individuals for the database or identifying someone to breastfeed an infant in urgent need by looking within IYCF-E services and seeking **referrals** from the community (e.g., community health workers, women's groups, traditional birth attendants) and other emergency services supporting pregnant and breastfeeding women and their infants. This requires awareness-raising, communication, training, the establishment of referral mechanisms and humanitarian accountability frameworks.
- At facility and community level, providing initial information to raise awareness in writing (e.g., leaflets distributed within health and nutrition services) or via posters or videos. Information can also be provided to groups of women, such as during group education or counselling, where interested women are encouraged to ask questions and privately address concerns. The engagement of religious and community leaders and male decision-makers in awareness-raising activities is also important.

xvi **For further guidance, see**: Global Nutrition Cluster Technical Alliance, Technical Brief: Supportive Spaces for Infant and Young Child Feeding in Emergencies, 2020. Accessible at: www.ennonline.net/supportivespacesiycfetechbrief2020

xvii International examples of such platforms include Human Milk for Human Babies and Eats on Feets.

Case Study 2A: Enabling wet nursing in compliance with religious law (or Sharia-compliant wet nursing) through documentation – The MyRadha'ah Card in Malaysia[113]

Background

Wet nursing is increasingly practised in Malaysia, where Islam is the predominant religion.[114] Consequently, more kinship ties are being formed between families. To prevent future problems, particularly concerning lineage (nasab) and improper marriage (mahram), documentation of milk kinship is therefore becoming increasingly important.[115] For milk kinship to be legal and binding, the identity of the wet nurse (murdi') must be clearly established.[116] In situations involving multiple wet nurses, records can establish who provided the most milk and is therefore considered the nursling's milk mother, a role which has social and legal implications and comes with certain rights and obligations.[117] [118]

Innovation

In 2018, the Selangor Islamic Religious Department in Malaysia introduced the MyRadha'ah Card, which was developed with religious scholars and authorities to serve as a formal documentation system for wet nursing arrangements and prevent potential Islamic law violations due to unrecognized milk kinship. The identity of the wet nurse and the nursling, alongside the duration and consent terms of the wet nursing arrangement, are recorded and stored for future reference. The card system is seen as a way to institutionalize documentation, making it more systematic, transparent and verifiable.

Benefits

The MyRadha'ah Card offers multiple benefits: it fosters community acceptance by enabling wet nursing to be practised in compliance with religious requirements, raises awareness by educating about the benefits and regulations of wet nursing within Islam, enhances legal clarity by providing a clear and formal record to avoid lineage disputes, and supports social protection by ensuring that all parties are aware of established kinship ties, which govern marriage eligibility and familial obligations under Islamic law.

Applicability for IYCF-E programming

The MyRadha'ah Card in Malaysia demonstrates how culturally sensitive programming can enhance the acceptability and practice of wet nursing. During emergencies, population displacement may complicate access to records and routine administrative systems may be disrupted, making adherence to religious requirements challenging for the emergency affected community. Responders should strive to understand any context-specific documentation requirements and how any pre-existing systems can be re-established or scaled up or consider creating their own stop-gap documentation.

Case Study 2B - Creating family bonds: Leveraging wet nursing to support orphans in Saudi Arabia[119]

This case study illustrates how religious laws, specifically the Islamic laws on wet nursing and milk kinship detailed in Box 1.4, can be harnessed and integrated into child protection programmes. In Saudi Arabia, milk kinship is a deeply rooted cultural and religious practice within the country's traditions and legal systems. Wet nursing was very common until recent socioeconomic changes and extensive BMS marketing altered breastfeeding practices and attitudes.[120] In this context, the Charity Orphans Care Foundation launched the "*Creating Relatives for Orphans through Breastfeeding*" programme. This initiative aims to enhance the social integration of orphans within the community by leveraging the concept of milk kinship and inviting volunteer women to care for and breastfeed abandoned or orphaned children. These children not only have their health and development supported by breastfeeding, but also legally recognized familial roots to support their psychological and social well-being. Reflecting cultural practices that prioritize community care, this project is an example of the holistic benefits that can flow from wet nursing for specific vulnerable groups.

D. MONITORING AND EVALUATION

ESTABLISH MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING SYSTEMS

Regular and periodic monitoring and evaluation are essential components of effective service delivery, enabling adjustments to improve outcomes. Monitoring and evaluation strategies should define objectives, target populations and expected outputs and collect baseline data and monitor the progress of planned activities. Monitoring and evaluation should measure the quality, quantity, coverage and utilization of services, and use programme and outcome indicators to measure impact. Monitoring and evaluation of wet nursing should be fully integrated into broader IYCF/IYCF-E reporting systems to ensure consistency and alignment with other health and nutrition interventions. Strengthening routine data collection on breastfeeding support is critical, as most systems do not yet comprehensively collect data on these areas.[121] Monitoring processes should include identification of quantitative and qualitative indicators and set targets.

The overall goal of wet nursing programmes is to reduce the number of non-breastfed infants and increase rates of exclusive and continued breastfeeding in order to promote child health and survival. Progress in wet nursing programmes can therefore be measured using programme output indicators for specific activities,[xviii] (such as the proportion/number of breastfeeding counsellors trained on wet nursing support and wet nurses screened or provided with breastfeeding support), alongside standard newborn and child health, nutrition (e.g., weight and mid-upper arm circumference measurement) and breastfeeding indicators to evaluate outcomes.[122] In line with the commitment to do no harm, outcomes for the wet nurse's own children, if any, should also be captured.

To obtain accurate prevalence rates for wet nursing, a clearly defined and standardized definition of the practice should be used *(see Box 1.2),* and data from standard IYCF indicators, such as exclusive or continued breastfeeding, can be disaggregated further by source of breastmilk to measure practices.[123] [124]

EXIT / SATISFACTION SURVEYS

Periodic satisfaction surveys or exit interviews can be used to capture the experiences and perceptions of wet nurses and caregivers. Conducted by phone, in person, or online, these assessments can provide valuable insights into the acceptability, feasibility and impact of wet nursing interventions, including perceptions of the practice itself and the support provided, such as counselling. Data can include positive outcomes, such as improved maternal well-being, positive relationships between mothers and wet nurses, as well as any unintended consequences, such as stigma or conflicts within families.

CONDUCT REGULAR EVALUATIONS

Regular programme evaluations should assess the impact of wet nursing programmes and identify any changes within the target population, such as improvements in breastfeeding rates. These evaluations can enable assessment of programme performance, effectiveness of service delivery, and support timely corrective action. Evaluations should be conducted periodically, especially after the launch of services, when making changes to existing services, or if population characteristics shift. Data should be used for action, with results documented and reported to inform ongoing and future programming.

DOCUMENT AND SHARE BEST PRACTICES AND LEARNING FOR FUTURE EMERGENCIES

There is very little recent documentation on experiences of supporting wet nursing in emergencies, especially compared to the large body of older, historical writings on the topic. Without contemporary evidence of impact or well-documented strategies, there may be reluctance to promote, fund or implement wet nursing interventions during emergencies. To overcome these barriers to scaling up, it is crucial that those implementing wet nursing programs systematically capture and share their learnings to inform future responses and promote child health and survival in emergencies.

Agencies can contribute by collecting and disseminating case studies worldwide to build a shared understanding of best practices.[125] Further research is needed to deepen understanding and strengthen the operational evidence base for wet nursing in emergencies. Exploring the implementation of wet nursing practices across all stages – from individual and community-level communication to the effectiveness of practical support and infection prevention measures would provide critical insight into operational challenges and successes.[126] Areas to consider in research should include how family dynamics and cultural factors influence acceptance of wet nursing.[127] Community-based participatory research approaches can help uncover these dynamics, fostering a deeper understanding of how sociocultural factors influence wet nursing practices. Methods such as focus group discussions and key informant interviews can engage family members and community leaders, revealing pathways to address resistance and build acceptance. Research on the experiences of wet nurses, mothers, and caregivers in wet nursing programmes, as well as the impact on child health outcomes, is also needed.

xviii For further examples of process or output indicators, see: World Health Organization, *Standards for improving quality of care for small and sick newborns in health facilities,* 2020.

CHAPTER 3

WET NURSE IDENTIFICATION AND SCREENING

GUIDANCE FOR FRONTLINE WORKERS AND PROGRAMMERS

The following section covers considerations, best practices and adaptations for identifying and screening women willing to provide wet nursing support that is *planned* and *supported* by emergency health and nutrition programmes. It describes a multi-step process that prioritizes infant survival while minimizing risk for all parties.

Given the limited resources, time constraints and operational challenges often faced in emergencies, this requires realistic, situation-specific identification and screening procedures to prevent avoidable malnutrition, morbidity and mortality among vulnerable infants.

A. WHO CAN BREASTFEED SOMEONE ELSE'S INFANT?

Potential wet nurses include:

- Breastfeeding women who are willing to breastfeed another infant alongside their own child[xix]
- Women who have previously breastfed/lactated and are willing to relactate[xx]
- Women who have never given birth or breastfed and are willing to induce lactation[xxi]

Lactation is critical to infant survival and is thus very robust and flexible. Indeed, it is possible to stimulate milk production and enable breastfeeding even in menopausal women and women who cannot become

xix This will require a willingness to work towards building milk supply, to breastfeed two or more infants.

xx Including women who have recently stopped breastfeeding, who breastfed and weaned in the past (even decades ago), and women who have been pregnant but not had a live birth. Lactation starts during the second trimester of pregnancy.

xxi It is possible for a woman who has never been pregnant or who has no ovaries or uterus to breastfeed an infant. The method for inducing lactation is the same as for relactation. Experiences and lessons can be applied from the practice of adoptive breastfeeding. For further guidance, see: Zaharah et al., Managing Induced Lactation: Making Breastfeeding Possible without Birthing, 2024.

pregnant for other reasons *(see Case Study 3A).*[128] [129] [130] However, during emergencies, the priority is to identify an already lactating woman who can meet an infant's immediate needs without delay. A short-term wet nurse can assist until a long-term arrangement is made. Culturally, beliefs about who can act as a wet nurse vary. Relatives, and sometimes known and trusted individuals such as close friends and neighbours, are often preferred as wet nurses by families *(see Box 2.1 and Case Study 3A).* [131] [132] [133] [134] However, this is not always the case, for example wet nursing by relatives may be discouraged in cultures practising both milk kinship and intra-family marriage.[135] Nonetheless, as discussed during life-threatening emergencies, cultural preferences or restrictions may become less important to caregivers and should therefore be re-assessed through community consultation.

Case Study 3A: Grandmother relactates to breastfeed grandchild in Northeast Nigeria[136]

Grandmothers are frequent wet nurses, especially in cases of maternal death. Since wet nursing by close relatives is often more accepted, programmes can consider supporting grandmothers with relactation to breastfeed a grandchild, if a family member who is already breastfeeding is not available.[137] The following case study illustrates this point.

Aisha, a grandmother in her 50s, cared for her granddaughter after the death of the baby's mother 40 days post-partum. Displaced by insurgents and lacking food and money, Aisha put her granddaughter to her breast. As it had been decades since Aisha's last childbirth, it took some time for her to relactate, and the infant's weight dropped below 2kg during that time. However, Aisha received medical, emotional and relactation support from a Save the Children supported clinic. The Supplementary Suckling Technique was used to support the relactation process, simultaneously ensuring the infant received adequate nutrition, enhancing her latching skills, and fostering bonding with her grandmother. This helped Aisha to successfully breastfeed, securing her grandchild's survival and health.

B. APPROACHES AND CONSIDERATIONS FOR IDENTIFYING POTENTIAL WET NURSES

Wet nursing arrangements are often privately made among family, friends or community members without external assistance, particularly in areas with an existing culture or tradition of wet nursing. This can be more challenging during times of crisis and displacement, when community and family networks are disrupted. IYCF counsellors can assist with identifying suitable wet nurses as follows:

- If the infant's mother is absent, begin by assessing if the current primary caregiver is willing to and can breastfeed. The close proximity of this caregiver will increase the likelihood of successful breastfeeding. Breastfeeding will also support caregiver-child attachment, and enhance caregiver ability to provide sensitive and responsive care.[138]
- Caregivers can be guided to seek a wet nurse within their family and community networks.[xxii] Ensure they are aware of the possibility of inducing lactation or relactating. Ask about close female relatives and friends, with sensitivity to the losses often faced during emergencies.
- Consider the following individuals, among others: [xxiii]
  - ✚ Grandmothers, aunts and other close female relatives of the infant
  - ✚ Adoptive and foster mothers
  - ✚ Female co-parents and co-wives in polygamous families
  - ✚ Neighbours and friends
  - ✚ Breastfeeding mothers who have a surplus of milk / oversupply
  - ✚ Lactating women who are not currently breastfeeding their infant (e.g., due to a rare infant medical condition or temporary separation)
  - ✚ Women who have recently experienced miscarriage, stillbirth or the death of their infant
  - ✚ Breastfeeding mothers who are attending emergency services
  - ✚ Peer breastfeeding counsellors and other volunteers
  - ✚ Local women's group members (e.g., mother-to-mother support groups)
  - ✚ Members of the host community, in areas with internally displaced persons and refugees

It is preferred for one woman to act as a wet nurse. In cases where this is not feasible, more than one woman may share the breastfeeding an infant. In these situations, however, vigilant monitoring of the infant's health and overall well-being is advised.

xxii **Preparedness action:** if there is a high risk of an emergency or personal crisis occurring in the near future, caregivers can be encouraged to identify someone who would be willing to wet nurse their infant if needed (also known as a *milk godmother).*

xxiii The above list is not exhaustive. Collaborating with local stakeholders and engaging the community in the identification process will help ensure a comprehensive and culturally appropriate approach.

Box 3.1: Special considerations for bereaved mothers and adolescents

Bereaved mothers: The experience of wet nursing by bereaved mothers can be varied. Women who have experienced loss during pregnancy, childbirth or shortly thereafter sometimes find that expressing and donating breastmilk to help others benefits their well-being, providing both physical and emotional comfort and helping them cope with grief.[xxiv] [139] [140] [141] However, breastfeeding another infant may also remind the mother of her loss and be distressing. In addition to mental health and psychosocial support (MHPSS), bereaved women and their families may benefit from trauma-informed counselling and written information on the options of lactation suppression, expression for human milk bank donation/informal milk sharing and wet nursing.

The appropriateness of wet nursing and its potential benefits and risks for a bereaved mother will depend on individual preferences and circumstances, such as whether the infant will remain in the woman's care in the future. The risk of causing significant psychological distress, which may arise by separating a bereaved wet nurse from a nursling she has bonded with, should be considered and communicated to support informed decision-making. Ideally, involved service providers should have basic psychosocial support skills[xxv] and a health care provider trained on mental health[xxvi] should monitor the mother. However, lack of access to mental health support for wet nurses should not prevent accepting offers from bereaved women if they express a desire to act as a wet nurse. The decision to donate breastmilk or wet nurse is personal and should be supported, without pressuring or inducing guilt for those who opt out. The process should follow the key principles highlighted in Box 3.2.

Adolescents: It is not recommended for programmers/responders to consider adolescents (individuals under 19 years of age) as potential wet nurses. Adolescents have increased nutritional requirements as they are still growing and developing.[142] Adding the nutritional demands of breastfeeding can be especially risky for adolescents as they are already at heightened nutritional risk, particularly in emergency contexts where food insecurity and/or other contextual risk factors for malnutrition are present.[xxvii]

There may, however, be exceptional circumstances where an adolescent wants to wet nurse a specific infant, for example a deceased sister's child. This may especially be the case if they are already breastfeeding and infant feeding alternatives are limited or non-existent. In situations like this, consider the adolescent's age, willingness, cognitive and emotional maturity, decision-making capacity, and overall situation, including support available. The heightened risks make comprehensive support essential. Coordinate with health and nutrition workers, child protection, education and MHPSS providers to mitigate risks and ensure the best interests of all parties involved.[xxviii]

During emergencies, adolescents face increased barriers to accessing sexual and reproductive health services, including breastfeeding counselling. IYCF counselling for adolescent wet nurses should be developmentally sensitive and tailored, focusing on their specific needs, risks, and preferences, and provided through adolescent-friendly services.[xxix] A concerted and respectful effort should be made to facilitate informed decision-making for adolescents, involving parents or legal guardians as appropriate, while respecting adolescents' right to bodily autonomy and privacy, thus ensuring there is no coercion.

xxiv There may be important differences between the experiences of wet nursing and human milk donation among bereaved mothers. While there is a growing body of research on human milk donation, research on wet nursing following perinatal loss was not identified.

xxv For guidance, see: MHPSS Minimum Service Package Guide, section 3.2: https://mhpssmsp.org/en/activity/activity-introduction-6#page-1.

xxvi Such as the mhGAP Humanitarian Intervention Guide (mhGAP-HIG). For guidance, see: MHPSS Minimum Service Package Guide, section 3.10: .www.mhpssmsp.org/en/activity/activity-introduction-13#page-1 and Acute Stress, Grief and Depression modules at www.who.int/publications/i/item/9789241548922

xxvii For guidance on assessing the nutrition situation for adolescent girls in humanitarian settings and identifying nutrition interventions to support adolescent wet nurses, refer to the 2024 UNICEF Programme Guidance to Protect the Nutrition of Women and Adolescent Girls in Humanitarian Settings

xxviii

xxix Peer counselling and support can be especially valuable for adolescents. Adolescent wet nurses may also benefit from emotional support, confidence-building, educational and informational support, practical help and assistance with strengthening their support networks. For guidance on ensuring adolescent-friendly services, see: Inter-agency Working Group on Reproductive Health in Crises, Adolescent and Sexual Reproductive Health Toolkit for Humanitarian Settings, 2020.

Box 3.2: Guiding principles for frontline workers supporting wet nursing in emergencies

Principle 1: Confidentiality and privacy

Transparency, information-sharing and direct contact between a wet nurse and the nursling's caregivers are important for ensuring safety and building trust. However, it is essential that the sharing of any personal and medical information is consensual. Securely store information, assure confidentiality and protect privacy for potential wet nurses, recipient infants and their caregivers. When identifying potential wet nurses in community settings, care should be taken to ensure that individuals who are screened out cannot be identified by community members.

Principle 2: Shared decision-making

Shared decision-making (*see Annex A, Definitions)* can positively influence wet nursing outcomes, including independent continuation of wet nursing. Caregivers and potential wet nurses should be provided with clear, accurate, adequate and balanced information as well as space to ask questions and voice any concerns. This supports them in making informed decisions that respect their unique circumstances, values and priorities.

Principle 3: Voluntary and consensual participation

Voluntary participation means that someone willingly chooses to breastfeed another person's child, without pressure, coercion or payment. Prospective wet nurses may also opt for self-exclusion, if they become aware they do not meet the wet nurse criteria.

Consensual means that both the caregiver and the wet nurse have reached an understanding and a voluntary agreement regarding wet nursing. The wet nurse must be empowered to agree or refuse to act as a wet nurse without pressure or coercion.

Principle 4: Cultural sensitivity

It is essential to respect and be sensitive to cultural norms and beliefs related to wet nursing and breastfeeding, such as religious beliefs or traditional practices. It is important for responders to understand cultural views, religious beliefs and traditional practices related to breastfeeding and wet nursing, such as use of any local galactagogues. Seek guidance from mothers, community leaders, local breastfeeding counsellors and cultural experts. Adapt language, protocols and guidelines accordingly.

Principle 5: Do no harm

'Do no harm' is a fundamental humanitarian principle that mandates humanitarian actors to avoid exposing emergency-affected people to additional risks or suffering through their actions.

Central to this principle is the screening process, which aims to ensure that a woman can serve as a wet nurse without adverse effects on herself or her family. For instance, during screening, counsellors can ensure that mothers are not pressured to act as wet nurses at the expense of early bonding and breastfeeding their own infants.

This principle requires careful consideration of the potential consequences of actions on everyone involved in wet nursing. For example, imposing external norms, foreign terminology or unfamiliar practices without understanding and respecting local traditions and knowledge can disrupt beneficial local practices.

The history of wet nursing shows that significant harms can arise when wet nursing is monetized, commercialized or implemented as a coercive and exploitative practice and when those involved are not adequately protected and supported. Lessons from the past should inform current interventions to ensure they prioritize the rights, dignity, and well-being of all involved and are subject to ongoing monitoring and evaluation to adjust practices that may lead to unintended harms. Risk mitigation strategies should be appropriately applied.

PROMOTION, EDUCATION AND COUNSELLING FOR WET NURSE RECRUITMENT

Breastfeeding counsellors and other trained frontline workers are vital in providing counselling to inform and help overcome concerns and misconceptions in women identified as potential wet nurses.

They should advise potential wet nurses as well as other decision-makers and influencers about the:

- **purpose and importance of wet nursing**, including expected benefits
- **potential challenges and burdens**
- **Screening process**, including the purpose (ensure safety and suitability), procedure (types of questions, medical tests and/or other assessments), follow-up (actions and support if health issues are detected), criteria (eligibility and exclusion), and confidentiality (records and results shared only with the wet nurse's consent)
- **Initiation of wet nursing,** including how agreements are formed
- **Available support** for wet nurses and their own children

Prospective wet nurses should be encouraged to ask questions. It is worthwhile to explain that women can usually breastfeed more than one infant and therefore can safely wet nurse alongside feeding their own baby, and that wet nursing is a natural and beneficial way to nourish infants whose own mothers cannot breastfeed them. Counsellors should discuss any religious or contextual issues that may be relevant, including, if appropriate, the cultural or historical relevance of these practices within the community. Combat any stigma associated with breastfeeding an infant one did not give birth to, recognizing the life-saving importance of these practices during emergencies. Ensure that prospective wet nurses fully understand the implications of screening, including the potential personal health outcomes and the subsequent steps if health issues are detected. This ensures they are fully informed and can consent to the process with a complete understanding of its significance beyond just determining eligibility for wet nursing.

C. BASIC CRITERIA FOR WET NURSES

In any given setting, basic criteria should be considered by emergency programmes supporting wet nursing to: a) help rapidly identify women suitable as wet nurses; b) improve the likelihood of success with wet nursing; and c) safeguard the well-being of the wet nurse, any of her own children and the nursling. It is preferable for the wet nurse to be:

- **Trusted and accepted** by the infant's caregivers/ family
- In good overall **mental and physical health**, with adequate **nutrition** status
- Part of the infant's household or living **nearby**
- **Supported** by her own family to breastfeed someone else's infant
- **Willing and motivated** to breastfeed someone else's infant

Box 3.3: Acceptance and trust

Caregivers possess a high level of discernment in deciding who may breastfeed their infant. Acceptance and trust between a wet nurse and the nursling's caregivers are vital for success, especially for longer-term arrangements.

Acceptance of a wet nurse can be influenced by cultural and personal values and community relationships. Caregivers may prefer someone who is breastfeeding her own infant or is related or well-known to them. Caregivers may have preferences for wet nurses who belong to the same community, culture or religion, as this strengthens caregivers' confidence that the wet nurse will uphold practices or values important to them. Religious beliefs may also influence preferences (see Box 1.4: Wet nursing and milk kinship in Islam). Potential wet nursing arrangements that do not meet these preferences should not be ruled out by emergency responders without consulting caregivers. The desire to protect the health and life of their infant may overrule these preferences, especially in emergencies. Facilitate open dialogue with the nursling's caregivers and wider community to understand, respect and address any cultural concerns or sensitivities related to trust and acceptance.

Box 3.4: Motivations for wet nursing

During emergencies, motivations for wet nursing primarily revolve around protecting the health and saving the lives of infants. Other common motivations are helping others and fostering a sense of community and maternal solidarity.

These motivations are strongest when there is good awareness of the importance of breastfeeding, especially during emergencies. Protection and promotion of breastfeeding in the general community is therefore key *(see 4C - Programming).*

Other motivations for wet nursing include comforting infants through breastfeeding[xxx] *(see Spotlight 1A),* maintaining breastfeeding as the cultural norm, religious beliefs,[143] cultivating connections between women, and supporting mothers' preferences for their infants to receive breastmilk.[144] [145]

Women may also breastfeed someone else's infant to manage their own breastfeeding difficulties, protect, maintain or build their milk supply (e.g., during separation), or to benefit from breastfeeding's contraceptive effect.

Foster and adoptive mothers may wish to breastfeed to bond with the infant and to support the infant's recovery from any early relational trauma, or in Islamic contexts, to create the milk kinship relational tie. Wet nursing may be practised to build a lasting relationship between individuals, families or communities.

Understanding common motivations for wet nursing can help to scale up wet nursing during emergencies by informing culturally sensitive communication. However, it is crucial to recognize that wet nursing can also stem from harmful sociocultural beliefs and practices, such as colostrum avoidance.[146] Safeguards must also be established to prevent women from being coerced into wet nursing by family members, for example who may be motivated for material gain if wet nursing is commodified or monetized.

D. KEY INFORMATION TO COLLECT DURING WET NURSE SCREENING

Screening potential wet nurses identifies and mitigates specific risks to safeguard all parties involved and protects the wet nurse from potential accusations or repercussions should health issues later arise for the nursling. With appropriate consent, sharing screening results can support informed decision-making, offer reassurance and address concerns from any involved parties.

Screening tools should be contextualized to capture the most serious and prevalent risks.[xxxi] Basic wet nurse criteria are universally applicable however, the importance given to each criterion and the detail of the information collected by screening tools should be tailored to the unique risks relevant to the context. To ensure the safety of the wet nursed infant, health and nutrition screening information for prospective wet nurses should include:

- **General health and nutrition status**, including pregnancy status[xxxii]
- **Mental health and emotional well-being**
- **Current medications and substance use**[xxxiii] [147]
- **Infectious exposures**[xxxiv] **and symptoms of infectious diseases of concern**
- **Relevant infectious disease tests and vaccination history**[xxxv]
- **Breastfeeding history, status and risk factors**[xxxvi] including any difficulties the wet nurse experienced in breastfeeding her own children, which may require skilled support
- **Exposure to chemical, biological, radiological and nuclear threats**[xxxvii]

xxx Breastfeeding can have calming and relaxing effects on both infants and breastfeeding women and provides analgesic effects for infants.

xxxi For an example of a screening tool, **see <**https://iycfehub.org/document/wet-nursing-screening-tool/**>.**

xxxii Breastfeeding during pregnancy does not generally pose any risk to the pregnant woman as long as she consumes adequate calories and nutrients for herself, her foetus, and any children she is breastfeeding. However, pregnant women may face food insecurity in emergencies and may experience a decline in their milk supply as a result of pregnancy hormones. It is therefore preferable that women who are not pregnant act as wet nurses during emergencies. .

xxxiii Some medications, such as contraceptive pills (oestrogen), can reduce milk production. Very few maternal medications and other therapeutics (e.g., radioactive compounds) are associated with adverse effects on breastfeeding infants; advice to stop or interrupt breastfeeding is often inappropriate, not evidence-based and not in the best interests of the infant. In the rare case where a medication is truly of concern, alternatives usually exist that could be used instead. **For further guidance, see:** LactMed database, available at: .www.ncbi.nlm.nih.gov/books/NBK501922/.

xxxiv Infectious exposures refer to situations or circumstances where the person may have been exposed to an infectious disease. These can include close contact with infected individuals (e.g., during hospitalization, caregiving), travel to/living in high-risk areas, occupational exposures (e.g., needlestick injury) and certain lifestyle or behavioural factors (e.g., intravenous drug use). In the context of wet nursing, this includes screening the wet nurse's own children for infectious diseases, which could pose a health risk to the nursling.

xxxv This includes test results that remain applicable, and vaccinations that are currently valid/active. Where available, refer to national guidance for disease-specific guidance on the validity of test results and vaccinations for breastfeeding women.

xxxvi Factors which place women at increased risk of experiencing breastfeeding difficulties include: breastfeeding multiples, living with a disability which impacts breastfeeding, severe illness, severe acute malnutrition, history of sexual or gender-based violence, recovering from a recent caesarean section/traumatic/high-intervention birth, adolescence, first time breastfeeding, history of breastfeeding difficulties, history of breast surgery, current or history of mental illness, diabetes, overweight or obesity. These are not exclusion criteria. Individuals who present with these risk factors can successfully breastfeed and should be prioritized for skilled breastfeeding support, per the IFE Core Group Operational Guidance: Breastfeeding Counselling in Emergencies, 2021.

xxxvii **For further guidance to inform screening and decision-making, see** IFE Core Group, Chemical, biological, radiological and nuclear (CBRN) threats in wartime situations: The impact on breastfeeding safety and IYCF practices, 2023: www.ennonline.net/cbrn-iycfe.

To verify that the identified woman is likely to be able to breastfeed someone else's infant safely without detrimental consequences to herself or her own child(ren), provided that she will be adequately supported, additional relevant screening information may include:

- **Health and nutrition status of the wet nurse's own child(ren)**
- **Caregiving capacity**, including the number, ages and needs of the wet nurse's own children, presence of sick or elderly family members and the support available to her[148]
- **Circumstances / domestic situation,** including the presence of any potential protection risks, such as gender-based or intimate partner violence
- **If breastfeeding the nursling in the wet nurse's own home is being considered,** additional considerations to ensure the nursling's safety may include:
  - **Housing conditions,** including sanitation facilities and any health and safety risks
  - **Accessibility** of the wet nurse's home, including distance, transportation options, climate and weather conditions, gender-based or cultural constraints (e.g., acceptability of women walking alone), and safety and security considerations (e.g., gender-based violence rates), especially for night-time feeds
  - **Protection and safety risks for the nursling,** such as substance abuse within the household or the presence of household members with severe or untreated mental health issues

The detection of any issues during screening does not automatically mean that wet nursing is precluded. Instead, additional information can guide decision-making and help identify measures to mitigate risks, ensuring safety for the nursling, wet nurse and her family. Screening tools should distinguish between absolute contraindications and manageable risks, offering clear guidance for providers. Recruitment and screening approaches that align with screening criteria enhance efficiency and reduce the burden of screening ineligible wet nurses.

Screening may be conducted in two stages: initial screening to identify clear exclusion criteria, at which point the process can be halted if any are found. Further screening can inform the decision-making process, whereby caregivers decide which risks are acceptable to them, considering each available feeding option and its associated risks. If wet nursing is chosen, the information gathered can guide risk mitigation strategies, such as counselling on alcohol or smoking. Women who are screened out may feel rejected, frustrated or excluded, especially if there is poor communication following screening or they feel that the exclusion criteria are unfair.[149] Providers should be equipped to sensitively communicate decisions, provide emotional support and make onward referrals for women who are willing to wet nurse, but are not considered eligible by wet nursing programmes.

E. METHODS FOR SCREENING WET NURSES

Even in an emergency setting, where for example, laboratory testing for infectious diseases is not feasible, various safeguarding steps can still be taken to rapidly screen wet nurses and reduce risks. **One of, or a combination of, the following screening methods can be facilitated by emergency programmes depending on resources:**

- Informal oral interview or written questionnaire
- Physical examination
- Screening/blood testing

Informed consent must be sought from prospective wet nurses before screening. Wet nurses may agree to a screening process, but decline certain tests. The preferred screening approaches that are agreed upon by prospective wet nurses and an infant's caregivers will depend on their levels of concern, and familiarity, and may range from a simple, honest conversation to laboratory testing.[150] Screening may be done in collaboration with various service providers, such as health workers and MHPSS providers, or may involve screening tools, such as questionnaires, provided directly to caregivers. Cultivate open communication and trust with prospective wet nurses, inviting them to share any medical or sociocultural concerns they may have. Assure them of confidentiality and a non-judgmental approach, creating a safe and supportive space that encourages disclosure.

Before screening begins, verify that the wet nurse understands that the screening may reveal health issues, and the results will be shared with her. Only with her express consent may results also be shared with the infant's caregivers to inform their decision on accepting her as a wet nurse. She should also be advised that if any health or other concerns are detected, she will be appropriately supported. If the screening occurs in a health care setting, then this care falls under the responsibility of health care providers.

When mothers make independent arrangements for wet nursing, they are selective about who they allow to breastfeed or provide breastmilk for their infant. Research indicates that women who breastfeed each

other's infants and know each other well, such as sisters or close friends, are often well-informed about each other's family health and lifestyle, comparable to the detailed screening done by blood banks, even if screening is not explicit or formal.[151] Any information, counselling, or screening that is offered in situations where the potential wet nurse is a family member or friend should acknowledge this and respect personal relationships, religious and cultural beliefs, and norms and customs. Caregivers and prospective wet nurses may also opt to have an open conversation between themselves.

PHYSICAL EXAMINATION

Health workers can identify and manage potential health and nutrition risks. Actions to detect such risks may include:

- **General examination:** A physical examination can be conducted by a health worker to rule out signs and symptoms of poor health, high-risk behaviours, such as intravenous drug use, and infectious diseases, which may be transmitted through close contact and/or breastfeeding.
- If a potential wet nurse reports symptoms related to her breast health, consent may be sought to examine her breasts to rule out infectious diseases that could be transmitted to the infant via sores, blisters or bleeding (e.g. Mpox, the herpes simplex virus-1 or syphilis).[xxxviii] Breast conditions such as engorgement and mastitis are not contraindications to breastfeeding, but they are indicative of breastfeeding difficulties with the wet nurse's own child(ren) and should be addressed with skilled breastfeeding support.
- **Nutrition status assessment:** Frontline workers can conduct anthropometric assessments of the wet nurse for determination on whether nutritional support or malnutrition treatment are required. Refer to national guidelines or context-specific emergency guidance for preferred anthropometric measurement methods and their cut-offs for pregnant and breastfeeding women. Screen for conditions such as anaemia (signs include pale palms and brittle nails) and wasting. Recognize that in many emergency situations, it may be difficult to find a wet nurse with optimal health and nutrition status and that women with a suboptimal status may still wish to act as a wet nurse. In such cases, focus on providing comprehensive counselling and support for informed decision-making and risk mitigation, including facilitating access to medical care, nutritional support, or food assistance as needed.

TESTING FOR INFECTIOUS DISEASE

Availability of testing for infectious disease in wet nurses and wet-nursed infants is a key facilitator of wet nursing during emergencies.[152] Depending on the feasibility of testing in a given context, prioritize testing for prevalent infectious diseases that have a *proven* high risk of severe illness and death in infants and *evidence* of transmission through close contact and/or breastmilk, such as Ebola virus disease.[153] Consult WHO for the latest recommendations on emerging infectious diseases that may justify a temporary avoidance of breastfeeding.

Additional tests may be carried out for small vulnerable newborns and critically ill infants in high-risk settings, including screening for human cytomegalovirus (HCMV IgG and IgM),[154] West Nile virus (WNV IgA and IgM) or tuberculosis.

In certain emergency situations, laboratory testing may not be feasible. Instead, rapid diagnostic tests may be used; however, even these may not be available during the most acute phase. When HIV testing is unavailable, WHO and UNICEF advise undertaking a risk assessment.[155] [156] The same principles can be applied to other infectious diseases of concern. Medical records may be available, such as those for vaccination or routine tests conducted during pregnancy or blood donation. Additional adaptations and mitigation measures for infectious diseases are covered in Section 3F, below.

When discussing the testing of prospective wet nurses for infectious diseases, especially in group settings and general communications, it is important to be clear that these tests are specifically suggested for individuals who are considering breastfeeding an infant other than their own. Breastfeeding mothers do not require the same level of testing to breastfeed their biological children.[xxxix] [157] [158] [159] With very few exceptions,[xl] breastfeeding should not be interrupted if a mother or wet nurse becomes infected with a disease after breastfeeding has started, as the infant is likely to have already been exposed to the pathogen before the woman developed symptoms. Stopping breastfeeding also does not remove other transmission routes, such as close contact or respiratory droplets, and instead deprives the infant of the protection offered by the immune factors found in her breastmilk and bonding. These points should be communicated clearly to the prospective wet nurse and her family members to avoid undermining breastfeeding practices.

xxxviii Herpes simplex virus-1 is spread through contact. Direct contact between breast lesions and the infant's mouth may transmit the virus; this is particularly dangerous for very young infants.

xxxix For instance, breastfeeding mothers are usually not tested for cytomegalovirus (CMV), because the virus typically poses minimal risk to their biological infants, who are protected by maternal antibodies. However, this differs in the case of wet nursing: a CMV-negative infant breastfed by a CMV-positive wet nurse could be at risk, especially if they are premature or immunocompromised, since they lack these protective antibodies. Therefore, testing wet nurses for CMV may be advisable to safeguard the health of the nursling and to protect the wet nurse against potential repercussions .

xl Including Ebola virus disease and brucellosis.

Box 3.5: Wet nursing in the context of HIV during emergencies[160]

The following summary is informed by the WHO and UNICEF 2018 *Operational Guidance on HIV and Infant Feeding in Emergencies:*

The aim of infant feeding interventions in the context of HIV is to prioritize the HIV-free survival of children by balancing HIV prevention with protection from other risk factors for child mortality. **HIV-free child survival** means that an infant or young child born to or breastfed by a woman living with HIV remains both uninfected by HIV and alive over a defined follow-up period.

The risk of HIV transmission through breastfeeding is extremely low when the breastfeeding woman adheres to antiretroviral therapy (ART). If a wet nurse is living with HIV and there are no other immediate alternatives for appropriate infant feeding, wet nursing may be continued together with appropriate risk mitigation measures.[161]

Screening and testing

Ideally, wet nurses should be counselled and tested for HIV. Immediate testing may not be feasible or a priority when a woman starts wet nursing at the onset of an emergency, but testing should be made available as soon as possible to ensure the safety of the infant and wet nurse. In settings with high HIV prevalence, health services should prioritise rapid HIV testing. In the absence of testing, an **HIV risk assessment** *(see Annex A: Definitions)* should be undertaken. Many women, even in an emergency setting, will have had an HIV test at some point. These results can help to inform HIV risk assessments.

Informed decision making

In an emergency scenario where infant formula is also available, the minimal risk of HIV transmission through wet nursing must be carefully weighed against the significant risks to infant survival associated with not breastfeeding and using BMS. If the only available wet nurse is HIV-positive, she may still be the infant's best chance of survival. Note that normative guidance is not yet available on wet nursing in the absence of ARVS.

Risk mitigation

Wet nurses whose HIV status is not known should be counselled on avoiding HIV infection during breastfeeding. If screening reveals that a prospective wet nurse is living with HIV, the risk of transmitting HIV to the infant can be significantly reduced through IYCF counselling to help ensure the infant is exclusively breastfed and to prevent nipple damage, and by supporting the wet nurse to access and adhere to antiretroviral therapy.[xli] [162]

Case Study 3B: Mutually beneficial wet nursing in Cox's Bazar refugee camp in Bangladesh

Background: In 2020, at Cox's Bazar, a four-month-old infant named Naima needed urgent nutritional support after her mother suddenly left due to a domestic dispute. This case study describes how wet nursing was established and supported to safeguard her health and survival, while also benefiting her new milk sibling by resolving breastfeeding difficulties. Action Contre la Faim, supported by Save the Children as the response's IYCF-E lead, managed Naima's care.

Assessing need and acceptability: Naima was identified as at-risk, due to not being breastfed through standard screening by services for the community management of at-risk mothers and infants under 6 months of age (CMAMI). Exclusively breastfed since birth, she was left in the care of her grandmother, Rehana, who was feeding her inappropriate BMS including milk powder, a follow-on formula not suitable for young infants as well as rice powder.[xlii] Wet nursing, while less familiar, was generally accepted within the primarily Muslim Rohingya community, supported by Islamic beliefs.[163] [164] The informed decision-making process with Naima's grandmother included counselling on the importance and superiority of breastmilk over BMS. Naima's grandmother acknowledged that artificial feeding was time-consuming and that she would prefer someone breastfeeding Naima. Following counselling, Rehana agreed to explore wet nursing as a preferable alternative for Naima.

Finding a wet nurse for Naima: Preference was given to household members, because safety risks and cultural norms would otherwise complicate night feeds. However, barriers such as rigid volunteer commitments and gender-based control, combined with lower awareness of the importance of breastfeeding among male community members and misconceptions about breastfeeding during pregnancy, hindered the search within the family.

- **Attempt 1 – primary caregiver:** Relactation was not feasible for Rehana, due to her household duties and commitments as an NGO volunteer.
- **Attempt 2 – Family member:** Mimi, Naima's aunt and household member, had breastfed her before, but was stopped by her husband as he was concerned about her pregnancy.

xli Although antiretroviral therapy is recommended, breastfeeding without it may still provide infants with the greatest chance of HIV-free survival during an emergency.

xlii Naima was being fed follow-on formula (a BMS marketed or otherwise represented as suitable for feeding older infants and young children 6–36 months of age) as her grandmother had difficulty understanding the product's labelling in a foreign language.

Case Study 3B (Cont.)

- **Attempt 3 – Neighbour:** Shahina, a 25-year-old mother nearby. Despite her willingness to help, she believed that breastfeeding difficulties with her own son, Fahim, would not allow her to wet nurse. She was feeding Fahim her expressed breastmilk, supplemented with infant formula. Fahim's suckling difficulties had led to low milk supply, and it had not been possible for her to stay at the stabilization centre long enough to fully establish breastfeeding.

Overcoming barriers:

- The team verified that Aunt Mimi would be able to rest and eat well enough to wet nurse Naima without harming herself or her pregnancy. However, efforts to counsel and reassure her husband were unsuccessful.
- Although initially uncomfortable with an unrelated wet nurse, religious motivation-based counselling that emphasized the life-saving importance of breastfeeding helped the family to accept Shahina, a non-relative.
- Shahina and her husband consented to the arrangement after the team explained that Naima suckling at Shahina's breast would stimulate her milk production and could benefit both children.

Screening and support: Shahina and Naima were screened using the **Community management of at-risk mothers and infants under 6 months of age** (CMAMI) checklist and both infants' CMAMI records were consulted to assess risks and support needs. The process included checking for danger signs, noting anthropometric measurements, evaluating feeding practices and difficulties, and assessing Shahina's mental health.

Recipient	Support provided
Shahina (the wet nurse)	• Continuation of provision of blanket supplementary feeding rations • Continuation of CMAMI services together with Fahim • Enrolment in CMAMI services together with Naima • IYCF counselling
Rehana (the caregiver)	• IYCF counselling • Practical help with bringing Naima to Shahina's house

Practical arrangements: Shahina visited Naima's home during the day for breastfeeding. At night, Naima was brought to Shahina's home by her caregiver, accompanied by a volunteer. This setup was monitored daily by community nutrition volunteers, and contact details were provided to notify the team of any issues.

IYCF counselling: IYCF counselling was provided via CMAMI services. Both Rehana and Shahina were counselled on hygienic artificial feeding and gradually decreasing BMS supplementation for the infants in their care. Shahina received breastfeeding counselling, focusing on building confidence in her ability to breastfeed both children. The counsellor also ensured that Rehana understood the importance of frequent breastfeeding for Naima, both day and night. Naima was initially breastfed every 2.5 to 3 hours. Once both women were familiar with Naima's feeding cues and patterns, she was breastfed responsively. They continued to attend the CMAMI corner together on a weekly basis for follow-up and needs-based counselling, such as on tandem breastfeeding positions, once Fahim started latching.

Outcomes: Follow-up visits indicated satisfactory weight gain and successful reestablishment of exclusive breastfeeding for Naima. As predicted, wet nursing enhanced Shahina's ability to feed her son, and she was eventually able to also breastfeed him entirely and directly. Aware of the importance of exclusive breastfeeding, Shahina was happy to breastfeed both children. In turn, Naima's caregivers were grateful for Shahina's compassionate act.

F. WHAT TO DO IF POTENTIAL RISKS ARE DETECTED DURING SCREENING

It is preferable for wet nurses to meet as many criteria as possible, however compromises may be necessary. Counsellors and health workers should be empowered to use their professional best judgement, supported by evidence-based policies and guidelines, to assist potential wet nurses and caregivers in making informed decisions about wet nursing. If concerns like infection are detected, the risks may still be outweighed by the life-saving importance of breastfeeding, which should be clearly communicated to caregivers. This section provides considerations for the decision-making process, as well as actions that can be taken to eliminate or minimize any risks identified during screening.

MITIGATING POTENTIAL RISKS IDENTIFIED DURING SCREENING.

Emergency responders play an important role in wet nursing, including through providing counselling on risk minimization, and offering practical help to ensure that the wet nurse and her family meet as many criteria as possible. For example, referral for medical treatment or working with camp management to ensure that the wet nurse and nursling are sheltered close to each other.

Wet nursing risk mitigation measures include:

- Standard risk mitigation measures to address general risks
- Specific risk mitigation measures to address risks detected during screening

Identifying risks through screening and implementing appropriate measures to address them helps safeguard all parties involved in the wet nursing arrangement.

INFORMED DECISION-MAKING

All infant feeding options carry some risk. The level of risk of each feeding option will vary depending on the context and available measures to manage or reduce risk.[165] In any given setting and situation, individual values and culture will influence which risks are considered acceptable.

If risks are detected when screening a prospective wet nurse, severity of the risk, the urgency of the situation and the feasibility of identifying an alternative wet nurse, or providing an alternative feeding option within the required time frame, need to be considered.

- **If *no* alternative wet nurses or infant feeding options are available,** decision-making is focused on determining how to reduce and manage potential risks. With support, some risks may even be eliminated. For example, nutritional support may alleviate a wet nurse's undernutrition and camp management may arrange for the wet nurse and nursling to be sheltered close to each other.
- **If alternative infant feeding options *are* available,** such as donor human milk or BMS, the decision-making process must first identify the safest option by considering the balance of risks associated with each available feeding option and their impact on child survival. If the decision is made not to proceed with wet nursing due to the presence of unacceptable or serious risks which make other feeding options safer or more acceptable than wet nursing, health care providers or other emergency responders conducting the screening should provide, or refer the screened woman for appropriate treatment or other necessary support, fulfilling their duty of care.

CHAPTER 4

OFFERING COUNSELLING AND SKILLED SUPPORT TO ESTABLISH, MAINTAIN AND STOP WET NURSING

GUIDANCE FOR FRONTLINE WORKERS AND PROGRAMMERS

This section offers practical guidance to health and nutrition workers, IYCF/breastfeeding counsellors and other trained frontline workers for delivering effective and appropriate information, counselling and skilled support to help ensure the safety and success of wet nursing during emergencies.

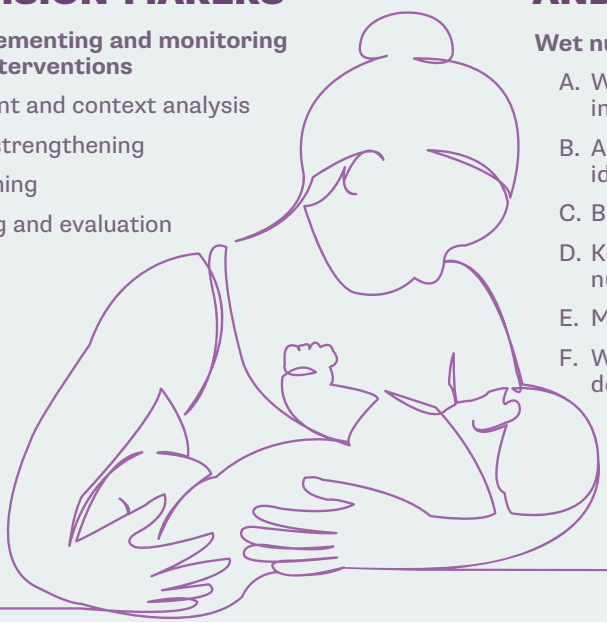
Support can include facilitating informed decision-making, identification and screening of wet nurses, risk mitigation and service referrals, as well as providing emotional support, education, practical help and counselling to help get wet nursing off to a good start and enable its continuation and eventual cessation.

The amount of support *required* will depend on the individual situations and needs. In contexts where wet nursing is familiar and/or widely practised, the provision of reassurance, encouragement and information about available support (such as screening services) by a supportive counsellor is likely to be enough. Counsellors may also encounter infants who are already being wet nursed. Appropriate actions should be carried out as soon as feasible, remembering that it is important to be flexible and adapt support to meet the specific needs and circumstances of each infant and his or her family.

FOR PROGRAMMERS AND DECISION-MAKERS

Planning, implementing and monitoring wet nursing interventions

A. Assessment and context analysis
B. Capacity strengthening
C. Programming
D. Monitoring and evaluation



FOR FRONTLINE WORKERS AND PROGRAMMERS

Wet nurse identification and screening

A. Who can breastfeed someone else's infant?
B. Approaches and considerations for identifying potential wet nurses
C. Basic criteria for wet nurses
D. Key information to collect during wet nurse screening
E. Methods for screening wet nurses
F. What to do if potential risks are detected during screening

A. ASSESS AND CONFIRM THE NEED FOR WET NURSING

SIMPLE RAPID ASSESSMENT

Caregivers of infants requiring wet nursing support may seek assistance directly from IYCF-E services or be referred from other services. Infants who are not breastfed or who are partially breastfed may initially be identified by frontline workers through screening using tools, such as the *simple rapid assessment,*[xliii] and referred for further assessment and support.

FULL ASSESSMENT

Once rapport and trust are established, counsellors can conduct a thorough individual-level assessment (*full assessment*[xliv]) to understand the specific circumstances and needs of the infant and caregiver (listen and learn) before determining the required infant feeding support (analyse and act). If the infant is not (fully) breastfed by his or her mother, relactation or increasing the mother's milk supply should be rapidly explored, followed by wet nursing or donor human milk. BMS should only be considered if none of these options are acceptable and feasible.

If the counsellor, following global recommendations and/or national policies and guidelines, determines that wet nursing is the most appropriate and safest option from the available infant feeding options, the next step is to establish whether wet nursing is:

- **Acceptable to the caregiver**
- **Feasible**

During the assessment, the counsellor will likely have started to develop an understanding of whether wet nursing might be possible and what information or practical help the caregiver may need. This can be further confirmed through the steps described below.

Consider how the infant will be fed *today*. If the caregiver does not have an appropriate feeding option available for the present and near future and a lactating woman is available and willing to breastfeed or express milk for the infant (even just for the short term), rapidly counsel the caregiver and seek their consent to start wet nursing or informal milk sharing immediately. If the need for breastmilk is critical, such as if the infant is sick, dehydrated or wasted wet nursing should begin immediately.[xlv] Screening and testing can be carried out after wet nursing has started. If these options are not viable, as a temporary measure, consider offering BMS and cup feeding support, until another feeding option is arranged.[xlvi]

CONFIRM ACCEPTABILITY

Inform and counsel the infant's caregiver(s): Ensure that caregivers have the information they need to make an informed decision about wet nursing, provided in a culturally sensitive manner. Counsellors should start by asking caregivers about their understanding of wet nursing, including any beliefs or experiences they or their community may have had with it, and adapt the information they share accordingly to build on existing knowledge and skills. Especially in cultures commonly practising wet nursing, a caregiver may already be considering wet nursing, but be reluctant to disclose it, because it has been stigmatized or discouraged by health workers in the past. In such instances, encouragement and reassurance that wet nursing is a recommended practice may be all that is needed.

Address concerns and misconceptions, if any: Sensitively address any questions, misconceptions or personal concerns that arise about wet nursing, including emotional concerns or fears, and provide reassurance that there will be further opportunities to discuss them.

Facilitate shared, informed, decision-making: Caregivers should understand that they have the right to make decisions about their infant's feeding and care. Ensure that caregivers and wet nurses are well-informed about wet nursing, including what it involves, why it is being suggested, potential burdens and challenges, expected benefits, the process for starting wet nursing, what ongoing support for wet nursing will be offered, and available alternatives to wet nursing.

xliii **For examples of simple rapid assessment tools, see:** IFE Core Group, Operational Guidance: Breastfeeding Counselling in Emergencies, 2021, Annex A; and United Nations Children's Fund, UNICEF Guidance on the procurement and use of breastmilk substitutes in humanitarian settings, 2021, Annex 2.

xliv **For an example of a full assessment tool, see:** IFE Core Group, Operational Guidance: Breastfeeding Counselling in Emergencies, 2021, Annex B.

xlv While rapid diagnostic tests should be used if readily available, the risk of transmitting infectious diseases such as HIV through breastfeeding is cumulative (i.e., the fewer number of times an infant is wet nursed, the lower the risk of transmission). and does not justify delaying the start of wet nursing in critical situations.

xlvi To minimize risks, BMS must be accompanied by an essential package of support and provided in strict accordance with global, or equivalent local, guidance. For global guidance, see: IFE Core Group, Operational Guidance on Infant and Young Child Feeding in Emergencies, 2017, Section 6.

CONFIRM FEASIBILITY

Considerations include whether wet nursing is practical given the caregiver's situation, if a motivated wet nurse is available for the infant, and if there are no contraindications for wet nursing *(see Box 4.1).*

Box 4.1 Infant conditions for which wet nursing is contraindicated

Wet nursing should *not* be provided for infants:

- Diagnosed with rare medical conditions that mean they should not be fed with any breastmilk, such as inborn errors of metabolism (including galactosemia, maple syrup urine disease and phenylketonuria).[166]
- Infected with, or exposed to, one of the few infectious diseases for which temporary avoidance of breastfeeding is recommended by WHO in case of infection and/or exposure, such as Ebola and other viral haemorrhagic fevers.

Note that paediatric HIV infection is *not* a known contraindication to wet nursing. Normative guidelines on infant feeding and HIV do not currently address Child-to-Breastfeeding Woman Transmission of HIV. In situations where the nursling is HIV seropositive, shared and informed decision-making is crucial. [xlvii] [167]

Find a suitable wet nurse: If the caregiver has not yet identified a potential wet nurse within the family or community network, counsellors can help to identify potential wet nurses, as described in Chapter 3.

Facilitate screening of all parties: Encourage screening of the potential wet nurse, the infant, and the infant's caregiver according to local policies and procedures and available resources and services, to ensure the health and safety of everyone involved in the wet nursing arrangement. Use the information gathered to support the best possible outcome for all parties. Screening of the potential wet nurse, infant and caregiver can involve assessing their health and nutrition status, including screening/testing for infectious diseases, as well as evaluating the mental health and psychosocial well-being of the potential wet nurse and caregiver and any protection risks within their homes, if this was not done during the initial IYCF assessment.

Confirm readiness and willingness to wet nurse: The goal of this step is to ensure that the potential wet nurse is willing and able to take on the responsibility of breastfeeding another mother's infant, without detrimental consequences to herself or her family, and understands clearly what this involves.

- **Manage expectations of the wet nurse and the nursling's family.** Inform potential wet nurses about the support available to them, such as coverage of transportation costs if relevant. Emphasize that participation is voluntary, can be withdrawn at any time, and is not a paid role. Ensure that the wet nurse understands that wet nursing is time-consuming and that the infant's needs may change (feeding frequency, duration of feeds).
- **Confirm willingness and motivation.** Remembering that consent is a continuous process, have a conversation with the prospective wet nurse to confirm that she is still willing to act as a wet nurse and to understand her motivations, ensuring they are altruistic rather than driven by a need for any support that is provided (*see Box 3.*4: Motivation).
- **Confirm availability.** Through observation, interaction and discussion, establish whether a potential wet nurse has the capacity and availability to breastfeed the infant as needed, including the required number of times each day and night, and that she has no immediate plans to move or travel. If the potential wet nurse's availability to breastfeed is limited due to the time and effort required to meet her own children's basic needs, her role as a wet nurse should be carefully assessed. Discuss these challenges and provide referrals or linkages to essential services to support her family's needs whenever possible.
- **Secure family and community support and acceptance.** It is important to include key decision-makers as appropriate to foster understanding, acceptance and support. In some cultures, women are expected to seek permission from their husbands or other family members before engaging in wet nursing. Counsellors should also verify that the wet nurse and any of her children will not be at risk of harm, such as from domestic violence from a non-agreeing partner or via community stigmatization. If such risks exist, discuss them with the wet nurse and consider strategies to mitigate them, such as including family members and community leaders in discussion, close monitoring and referral to appropriate services.
- **Ensure there is no coercion or pressure:** All parties must understand and agree that the arrangement is voluntary and that the wet nurse has the right to withdraw at any time for any reason. In a private conversation, confirm that the prospective wet nurse

xlvii Available studies all involve transmission between infants and their biological mothers. However, transmission is possible whenever an HIV positive infant is breastfed by an uninfected woman, including a wet nurse, and likely occurs when broken skin comes into contact with blood. An evidence review found that the risk of HIV transmission may be higher than previously recognized, with transmission rates between 40% and 60% in cases where mothers breastfed their biological infants post-nosocomial infection. The specific transmission risk of breastfeeding HIV positive maternal orphans is unknown. However, transmission is preventable. Transmission risks are considered elevated for cross nursing, which may involve multiple infants and women over extended periods of time and may result in transmission to multiple infants and breastfeeding women. Acceptability of wet nursing HIV-positive infants varies widely, but is generally higher in situations of orphanhood, particularly if the wet nurse is a female relative. A wet nurse considering breastfeeding an HIV-positive infant, or an infant whose HIV status is unknown in a high-prevalence area, should be engaged in a shared and informed decision-making process which makes her aware of the risk of acquiring HIV through breastfeeding. Counselling and HIV testing for both the infant and the wet nurse, as well as skilled support and counselling on reducing the risk of acquiring HIV during breastfeeding, are essential for informed decision-making and risk mitigation.

is voluntarily agreeing to participate of her own free will. Be aware of potential coercion, such as family members pressuring someone to wet nurse for access to support, which could involve intimate partner violence. While wet nursing by a close friend or relative can be rewarding, it is important to ensure that the potential wet nurse does not feel obligated to help due to the relationship.

B. MAKE REFERRALS AND LINKAGES[xlviii]

The goal of referring and linking is to create an enabling environment and ensure that the infant, caregiver, wet nurse, and their families have access to the support and risk mitigation measures they need to ensure a successful wet nursing arrangement, without negative consequences.

STANDARD SUPPORT

All cases should be referred or linked to the following services, if available and appropriate:

- **Further IYCF-E services:** Wet nursing has been shown to continue for longer when wet nurses have adequate knowledge on IYCF-E and wet nursing.[168] Linkages may include group education sessions for wet nurses and family members, providing skilled relactation support to the infant's caregiver or invitations to attend supportive spaces, such as Mother Baby Areas or Nurturing Care Centers.
- **Community support:** Establish linkages with community support networks. This could include recording important information for milk kinship or connecting the caregiver and the wet nurse to peer support networks and other programmes, such as mother support groups or women's income generation groups, and links with other services in the community that may alleviate time burden and increase access to resources.
- **Food assistance:** Connect and refer wet nurses to food assistance programmes for breastfeeding women.

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

MHPSS support needs increase during emergencies[169] and wet nursing has multiple mental health and psychosocial implications. Caregivers may have faced challenging or traumatic circumstances that created the need for wet nursing. If present, the infant's mother may experience difficult emotions related to the perceived loss of her maternal identity or feelings of failure, shame, disappointment or grief if breastfeeding ended earlier than she desired.[170] These feelings may be amplified by witnessing someone else breastfeeding her child. If the infant's mother has died, the current caregiver may be grieving and if the wet nurse is a bereaved mother herself, she also will be grieving. However, the sharing of care of an infant by mother and wet nurse is not always distressing. It can also result in friendship and feelings of strength arising from women helping other women.

Family members, including the wet nurse's own children, may also require support. As the infant and wet nurse are likely to bond, the end of the wet nursing arrangement can be an emotionally challenging time requiring compassionate support. In addition to supporting referrals to MHPSS, it is important for counsellors to be trained on psychological first aid and the provision of universal trauma-informed care where feasible.

SPECIFIC IDENTIFIED SUPPORT

Referrals should be made to address any specific risks or needs identified during screening and individual assessment. For example, wet nurses experiencing household food insecurity may be referred to food security and social protection services, such as food distributions or cash transfers. Referrals could also facilitate shelter arrangements for proximity and safety or arranging transportation of infants or wet nurses for breastfeeding.

After making a referral, it is important to follow up. Advocacy may also be required to ensure that the referred person receives the necessary services, especially if wet nursing is not supported by large-scale emergency programmes or is unfamiliar to emergency responders. For example, there may be confusion regarding the provision of food assistance intended for pregnant and breastfeeding women to a grandmother acting as a wet nurse, or to a wet nurse who does not have her own children.

xlviii For further guidance on referrals, see: IFE Core Group, Operational Guidance: Breastfeeding Counselling in Emergencies, 2021, Referral Systems, pages 21-22; and UNICEF and WHO, Implementation Guidance on Counselling Women to Improve Breastfeeding Practices, 2021, Chapter 5.

C. INITIAL SUPPORT FOR ESTABLISHING WET NURSING

REACH AGREEMENT ON THE PRACTICAL ASPECTS OF WET NURSING

It is important to establish a clear agreement about the wet nursing arrangement, which the wet nurse, her family, and the infant's caregivers are all comfortable with. There can be challenges with wet nursing in emergencies including misunderstandings with family members, limited availability of the wet nurse and difficulties in travelling between households.[171] Reaching agreements on the practical aspects of wet nursing is crucial to ensure a successful arrangement, particularly if the wet nurse and caregiver do not know each other well. Facilitate open and clear communication with all parties involved about expectations, responsibilities and practical arrangements.

Following an introductory meeting between wet nurse and caregiver (if applicable), counsellors can facilitate a more structured discussion about practical arrangements, including an assessment of the specific situation, identification of potential challenges and solutions, and development of a clear plan. Considerations include:

- **Breastfeeding frequency and technique:** Discuss the optimal pattern of breastfeeding, including frequency, duration and responsive feeding. Agree on the approach to breastfeeding, whether on demand/responsive or scheduled. Responsive feeding is best, but may not be feasible, depending on factors such as the wet nurse's proximity, availability and flexibility. Scheduled feeding is an acceptable compromise, especially for older infants and young children, but will require more intensive infant monitoring. Regardless of the approach, it should be understood that the duration of each breastfeed should not be restricted.
- **Location:** Agree where wet nursing will take place, ensuring it is a safe space for everyone involved. Options include communal spaces, Nurturing Care Safe Spaces/Centers and Mother Baby Areas[xlix], the wet nurse's home, or the infant's home. Consider cultural norms and risk of gender-based violence, if applicable, and facilitate safe transportation.
- **Managing night feeds (how and where)**: Counsel on the importance of breastfeeding at night for infant nutrition and growth, preventing breast engorgement and protecting milk supply. Recognize that it may not be safe, feasible or acceptable for the infant's wet nurse or caregiver to travel at night if they do not live together. Possible options include:

xlix For example, a Mother Baby Area or night feeding shelter. Consider opening hours and safety for night feeds.

- ✚ It is best for the infant to be responsively breastfed at night. However, establishing a night feeding schedule is an acceptable compromise, especially for older infants.[l] Back-up plans should be established to avoid the caregiver resorting to practices that are risky (such as giving tea or water to a young infant) to avoid burdening the wet nurse if the infant cries or wants to be fed sooner than planned at night.
- ✚ If the wet nurse is a trusted relative or friend, it may be acceptable for the infant to stay with her overnight, but this option should be carefully assessed in consultation with child protection experts and may require additional screening, including a home visit.
- ✚ Alternatively, the wet nurse can express breastmilk for the caregiver to cup feed to the infant or an alternative source of donor human milk can be identified.[li] This requires the provision of breastmilk storage and feeding equipment, as well as counselling on hygienic expression, storage and responsive cup feeding.
- ✚ As a last resort, cup feeding an appropriate BMS can be considered, acknowledging that any breastfeeding, even in combination with a BMS, is preferable to exclusive artificial feeding as it still provides valuable protection to the infant.

- **Continuity of care and communication:** Ideally, the infant should be wet nursed by the same woman for as long as the infant needs it (i.e., until full maternal breastfeeding is re-established, until an alternative breastmilk feeding method is secured, or until at least 6 months of age). Aim to ensure continuity of care and minimize disruptions for the infant. This includes agreeing to promptly share any plans to move or changes in availability, establishing back-up care plans, and ensuring means for all parties to communicate. Where wet nursing by one woman alone is not possible, wet nursing can be shared. However, this introduces risk as dispersion of responsibility to feed also means dispersion of commitment. Closer health and growth monitoring should be put in place to ensure that the infant is getting sufficient milk.
- **Protecting the infant's health and well-being:** Discuss the caregiver's expectations of the wet nurse to keep the infant safe, healthy and free from infection. This should include counselling and agreements to avoid high-risk behaviours while wet nursing, such as having multiple sexual partners or smoking near the infant.
- **Boundaries:** Assist in setting clear boundaries for the wet nursing arrangement. This could involve discussions about privacy and the duration of the wet nursing arrangement. It is normal and beneficial for the wet nurse to bond with the infant. It is equally important to be considerate of the emotions of the infant's mother or other primary caregiver and to safeguard their bond.
- **Compensation/remuneration:** Discuss expectations regarding compensation. While breastfeeding should not be commercialized, support, products or supplies to support well-being and[172] breastfeeding may be provided. In some cultures, there may be historical or religious precedents for compensation. However, unless policies state otherwise, it is important to ensure that the wet nurse is participating voluntarily and without expecting compensation.
- **Cultural understanding of wet nursing:** Clarify what wet nursing means to each party. In some cultures, wet nursing may be seen as an informal adoption, or involve the wet nurse becoming a milk mother, and her children becoming milk siblings to the infant. In cultures where marriage between milk siblings is prohibited, explain how these relationships will be recorded to prevent future difficulties.
- **Community involvement:** If appropriate, involve the wider community in supporting the wet nursing arrangement. This could involve community leaders, religious leaders, health workers, partners, family members, peer counsellors or others who have experience with wet nursing.

SUPPORT THE WET NURSE TO START BREASTFEEDING THE NURSLING

Skilled support can help ensure a successful start to wet nursing, particularly for inexperienced wet nurses. Counsellors should assess and address information and practical support needs, offering anticipatory guidance and assistance with breastfeeding as required.[lii]

If possible, it is best to conduct the first attempt in a quiet and comfortable setting, with everyone supported to feel as safe and calm as possible. Any questions or concerns should be addressed. Recognizing that breastfeeding is not just a physical act, but also an emotional one, it may be helpful to share that it is normal and common to

l The younger the infant, the more likely it is that scheduled (restricted) breastfeeding will cause stress for both the infant, the caregiver and the wet nurse. Young infants, especially newborns, should be breastfed 3–4 times during the night, with intervals of 2–3 hours, allowing for one longer stretch of up to 4 hours for sleep. As infants grow, they may begin to sleep longer at night and require fewer night feeds. By 6–12 months of age, some infants may be able to sleep through the night without breastfeeding. However, others may still require one- or two-night feeds, particularly if they are not consuming a lot of complementary foods during the day.

li It is best for the wet nurse to express breastmilk at least every three hours during the night, to be fed to the infant the following night. This depends on the age of the breastfeeding child; as an infant gets older, the frequency of nighttime feedings will decline.

lii For further guidance, see: UNICEF United Kingdom, Education Refresher Sheet – Supporting effective breastfeeding.

experience strong emotions related to wet nursing, which may be positive or negative.[173]

Most infants readily accept the breastmilk of a woman other than their mother.[174] [175] With the caregiver's agreement, the wet nurse can hold the infant skin-to-skin and interact with the infant to help the infant feel secure and stimulate the wet nurse's hormonal response to significantly and rapidly increase milk supply.[liii]

Some infants may initially refuse to breastfeed from the wet nurse, particularly older infants. This can be a challenging situation that requires patience, confidence and gentle perseverance, but it can usually be resolved with skilled breastfeeding support and/or frequent close contact, ideally skin-to-skin.[liv] An infant should never be forced to breastfeed; patience is important to avoid rushing the process. If appropriate, keep the dyad together in skin-to-skin contact for some time before intervening. In addition to standard approaches for managing refusal to breastfeed, having the wet nurse wear an item of the caregiver's clothing, such as a scarf, may also help in soothing the infant with the familiar scent of the caregiver.

Once breastfeeding begins, counsellors should ensure that the infant is well attached and suckling effectively and that breastfeeding is comfortable for the wet nurse.[lv] If direct breastfeeding is not immediately established, the wet nurse can be supported in the drop drop method, and/or the infant can be cup or spoon fed with the milk expressed by the wet nurse instead.

Further skilled support may be required, depending on the situation:

Scenario 1: Wet nurse is inducing lactation, relactating or needs to increase milk supply

It is important to assess whether the wet nurse can fully meet the infant's nutritional needs as soon as wet nursing has begun or whether temporary supplementation (with donor human milk or BMS) is necessary for the nursling or for the wet nurse's own child.[lvi] Women who are inducing lactation or relactating to wet nurse will require some time to start and then gradually increase their milk production. Wet nurses who are already successfully breastfeeding their own child(ren) can typically boost their milk supply rapidly, often within a few days, to meet the nutritional needs of all their breastfed children.

However, they should be prepared to expect very frequent feeding by both infants during this time until their milk supply stabilizes.

Priority should be given to first meeting the nutritional needs of the wet nurse's own breastfeeding children with her breastmilk. The infant being wet nursed may therefore require supplementation at first. This should be provided along with counselling and skilled support aimed at increasing the wet nurse's milk supply and gradually reducing the need for supplementation.[lvii] Alongside weight changes, stool and urine output (six or more times a day indicates good intake of breastmilk) as well as their smell, colour, volume and frequency (for all children the wet nurse is breastfeeding) should be closely monitored, while working to increase supply as immediate indicators of nutritional intake and to detect potential dehydration.

Scenario 2: Infant's mother is present and relactating or needs to increase milk supply

In situations where the infant's mother is present, wet nursing is ideally a temporary solution until maternal breastfeeding can be re-established. If a mother is willing and able to relactate or increase her breastmilk supply, a wet nurse can support the process until the mother's own breastmilk supply is fully established. Such cross feeding ensures that the infant is exclusively/fully breastfed and is not exposed to the risks associated with BMS.

The infant's mother should be provided with counselling and skilled support to increase her breastmilk supply, and counselled on recognizing reliable signs that her baby is getting enough milk. Both the mother and the wet nurse may benefit from counselling on how to balance their milk production against each other's breastfeeding patterns. For example, if the mother's own supply rapidly increases, the wet nurse may require support to prevent breast conditions such as engorgement until her milk supply decreases.

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liii For further guidance on helping the wet nurse's milk to flow, see: WHO and UNICEF, IYCF counselling: an integrated course, 2021, p.43 - Course handouts. How to stimulate the oxytocin reflex. Available at: www.who.int/publications/i/item/WHO-HEP-NFS-21.41

liv For general guidance on the management of refusal to breastfeed, see: WHO and UNICEF, IYCF counselling: an integrated course, 2021, page 48 - Session 30: Refusal to Breastfeed and Course Handouts: Helping a mother and baby to breastfeed again.

lv A breastfeeding observation tool can be used, such as: WHO and UNICEF, IYCF counselling: an integrated course, 2021, page 23 - Course handouts. Job Aid: Breastfeed Observation. Available at: https://www.who.int/publications/i/item/WHO-HEP-NFS-21.41. For video resources on positioning and attachment, see: https://globalhealthmedia.org/topic/breastfeeding/.

lvi Supplementation options include formal and informal donor human milk and, as a last resort, an appropriate BMS. To stimulate the wet nurse's breastmilk production, it is best for supplements to be provided at the breast, ideally with skin-to-skin contact. Supplements may also be cup- or spoon-fed by the infant's caregiver. At-the-breast supplementation techniques include the Drip Drop Method and the Supplementary Suckling Technique. The Drip Drop Method is safer in contexts where hygiene is a concern. For further guidance on Drip Drop Feeding, see: https://llli.org/news/drip-drop-feeding/.

lvii For infants under 6 months of age, aim to establish exclusive breastfeeding. For further guidance, see: UNICEF United Kingdom Baby Friendly Initiative, Maximising Breastmilk and Relactation, available at: https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2020/03/Unicef-UK-Baby-Friendly-Initiative-Maximising-breastmilk-and-re-lactation-guidance-2.pdf

Box 4.2: Methods to support mothers to relactate or increase milk supply with wet nursing

- **Cross feeding:** The infant starts breastfeeding at the mother's breast. If they are not yet showing satiation (fullness) cues when the mother's milk flow slows down or stops, the wet nurse takes over and the mother hand expresses for a few minutes to further boost her milk production. Alternatively, if the infant rapidly shows signs of frustration due to the mother's low milk supply, the sequence can be reversed: after being calmed by the wet nurse's milk, the infant finishes at the mother's breast and settles to sleep, ideally skin-to-skin, on her chest. This method enhances emotional bonding and reassurance, helping the infant associate comfort and contentedness with the mother's breast. [176]
- **Informal milk sharing:** The wet nurse (donor) expresses breastmilk to complement the mother's milk and ensure the infant receives adequate nutrition. To simultaneously simulate milk production, the milk is ideally fed to the infant at the mother's breast. At-the-breast supplementation techniques include the Drip Drop Method and the Supplementary Suckling Technique.[lviii]

D. CONTINUED SUPPORT FOR MAINTAINING WET NURSING

MONITOR AND FOLLOW-UP

The wet nurse, the infant's caregiver and both their families should be adequately supported throughout the wet nursing period. While the timing, frequency and duration of required support will vary depending on the specific situation and needs of the individuals involved, the activities outlined below should be considered by programmes supporting wet nursing to help ensure its success and the well-being of all parties.

- **Monitor health, nutritional status and overall well-being,** including growth of the nursling and any of the wet nurse's own children
- **Provide ongoing breastfeeding counselling and skilled support.** Weight gain and other indicators of good breastmilk intake, such as stool and urine output, developmental milestones, and mid-upper arm circumference measurement should be monitored in all children being breastfed by the wet nurse. Aim to conduct two breastfeeding assessments in the first week of wet nursing, assessing criteria such as feeding frequency, duration and behaviour, sucking patterns, weight, urine and stool output, and the wet nurse's breast health.[lix] Further assessments should take place as required in response to any breastfeeding challenges.
- **Identify and address any emerging fears or concerns**
- **Support the wet nursing relationship and family dynamics.** Ensure that everyone remains satisfied with the arrangements for wet nursing
- **Follow-up on referrals made to other services and facilitate access, as needed (e.g., for nutritional support)**
- **Regularly review and adjust the wet nursing arrangement as needed:**
  - ✚ Confirm the wet nurse's continued willingness and ability to breastfeed the nursling
  - ✚ Adapt to the evolving needs of the nursling and the wet nurse
  - ✚ Evaluate the need for continued wet nursing and/or supplementation (e.g., during relactation)
  - ✚ Plan for the transition when wet nursing is no longer required or feasible

E. SUPPORT FOR ENDING WET NURSING

SUPPORT THE CESSATION OF WET NURSING[177 178]

The transition for when wet nursing is no longer required or feasible should be planned for in advance, considering both the immediate and longer-term nutritional needs of the infant and the emotional and physical well-being of all involved, to allow for a smooth and compassionate transition. Ideally, wet nursing should continue until an infant can be fully breastfed by his or her mother or caregiver or is old enough to fully meet his or her nutritional needs through family foods.

lviii Supplementary Suckling Technique uses a feeding tube attached to a container filled with donated, expressed breastmilk (or BMS). The tube's other end is placed alongside the woman's nipple, so that as the infant breastfeeds, he or she draws milk from both the tube and the breast, which stimulates milk production. For further guidance, see: www.youtube.com/watch?v=eP5Aun8AfK0 and Management of Acute Malnutrition in Infants Counselling Card A24, available at https://resourcecentre.savethechildren.net/pdf/MAMI-Counselling-Cards-standard-version-horizontal.pdf/. Alternatively, the Drip-Drop Method uses a clean spoon to gently and steadily drip milk down the breast to the nipple. For further guidance, see: https://llli.org/news/drip-drop-feeding/. Both methods encourage the infant to suckle and stimulate milk production while also receiving nurturing and comfort, and are effective ways to support induced lactation and relactation, or to increase supply to enable a woman to wet nurse another infant alongside her own. However, due to challenges in adequately cleaning and replacing feeding tubes, the Drip-Drop Method is preferred in emergency settings where hygiene cannot be assured.

lix For further guidance, see UNICEF United Kingdom Baby Friendly Initiative, Education Refresher Sheet: Completing a Breastfeeding Assessment at www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2020/05/Education-refresher-sheet-7-completing-a-breastfeeding-assessment.pdf.

Suggested actions are as follows:

- **Assess readiness and circumstances.** How much and what support is needed will depend on the emotional and physical readiness of both parties to end the wet nursing arrangement and their circumstances. Consider factors such as: the infant's age, health and nutrition status, and alternative feeding options including caregivers capacity to breastfeed the infant, the wet nurse's physical and mental health and psychosocial well-being and whether she is breastfeeding any other children; the degree to which the wet nurse and nursling have bonded; and whether they will continue to have contact with each other.
- **Plan a gradual transition.** Abrupt cessation of breastfeeding should be avoided. Counsel on gradually reducing breastfeeding frequency to allow the wet nurse and nursling to adjust physically and emotionally, including easing the nursling into a new feeding method. This is particularly important if the wet nurse is not breastfeeding any other children, as it helps protect her breast health and mental health. If wet nursing is used to support the infant's mother to relactate or increase her milk supply, a natural transition will occur. In situations where a gradual transition is not possible, such as if either party must suddenly relocate, the wet nurse can be shown how to express small amounts of breastmilk and counselled on managing potential engorgement and emotional distress. Follow-up support should be intensified to monitor and address any complications from the abrupt change.
- **Introduce appropriate alternative feeding options.** Depending on the age and nutritional needs of the infant and the availability, feasibility, affordability, sustainability and safety of feeding alternatives, identify suitable alternatives, such as exclusive breastfeeding by the infant's mother, breastfeeding by a new wet nurse or using donor human milk as options (in order of preference). If the infant is above six months of age, full fat animal milk can be used alongside diverse complementary foods. Ensure the infant's caregiver is counselled on and supported to feel confident and competent with appropriate feeding techniques and relevant hygiene practices. Enable access to ongoing IYCF-E support.
- **Provide emotional support and counselling.** If the wet nurse and nursling will not continue to see each other, reducing contact gradually can help prevent a traumatic loss for the infant/child and safeguard their mental health. Acknowledge the relationships and bonds formed, such as between the wet nurse and the infant, and the infant's mother. In the likely event that the wet nurse has developed a bond through breastfeeding, respect and support any feelings of grief, loss or sadness. If feasible, maintaining some in-person contact or sharing updates about the infant's well-being can help cope with the separation.[179] Build the mother or other primary caregiver's confidence, support the strengthening of bonds if these were disrupted by wet nursing, and address any emotional difficulties, such as feeling a loss of support or overwhelmed by the new feeding responsibilities.[lx] Refer to mental health and psychosocial support services (MHPSS) for more comprehensive support, as needed.
- **Facilitate contact information and/or documentation.** Support an exchange of personal information and contact details to address any future issues that may arise. In most contexts, including where Islamic milk kinship is practised, this will suffice. In some contexts, documentation to record the relationship established through wet nursing may also be required.
- **Ensure follow-up and ongoing support.** Arrange for regular follow-up to monitor the adjustment for both caregiver and infant, paying attention to their health, growth and emotional well-being, and provide ongoing IYCF-E support as needed.

lx Such disruptions of mother-infant bonds should be prevented during wet nursing by suggesting activities other than breastfeeding that enhance physical closeness and emotional connection, such as skin-to-skin contact.

CHAPTER 5

PROTECTING, PROMOTING AND SUPPORTING WET NURSING

GUIDANCE AND CONSIDERATIONS FOR POLICY-MAKERS AND OTHER DECISION-MAKERS

Wet nursing is a long-standing and widespread breastfeeding practice that can benefit children, women, families and communities in numerous *ways,* especially during emergencies. Wet nursing is recommended by WHO, UNICEF the IFE Core Group, the Sphere Standards, and endorsed by the World Health Assembly.[lxi]

The inclusion of wet nursing support within national and subnational emergency preparedness and response plans requires clear and coherent policies and guidelines, as well as adequate resources and political commitment. This chapter offers considerations and recommendations for policy-makers and decision-makers to ensure that wet nursing is appropriately supported as part of IYCF-E responses.

A. GLOBAL POLICY

GLOBAL GOALS AND TARGETS

To achieve the Sustainable Development Goals, Global Nutrition Targets,[lxii] and other global and national goals and targets, breastfeeding support must be prioritized. For decision-makers, understanding the importance of

lxi Global documents that recommend wet nursing and donor human milk include the WHO 2022 Global Strategy for IYCF (endorsed by the World Health Assembly and adopted by UNICEF), the IFE Core Group's 2017 Operational Guidance on IYCF-E and the Clinical management of COVID-19: living guideline, 18 August 2023. Geneva: World Health Organization; 2023 (WHO/2019-nCoV/clinical/2023.2).

lxii One of the World Health Assembly Global Nutrition Targets is for 50 per cent of infants to be exclusively breastfed by 2025. See: https://www.who.int/publications/i/item/WHO-NMH-NHD-14.2. Furthermore, the target for breastfeeding is a precondition to achieving its other Global Nutrition Targets.

breastfeeding is foundational for any strategy aimed at effectively safeguarding the health, well-being and survival of infants and young children and mothers, especially during emergencies. This should include explicit recognition of wet nursing as a form of breastfeeding in settings where the practice is acceptable and feasible.

Feeding breastmilk from someone other than an infant's own mother, such as a wet nurse, when the mother is unavailable or her breastmilk is insufficient, is part of a policy and practice for ensuring more infants are breastfed as recommended.[180] Policy-makers should therefore consider wet nursing as part of the matrix of solutions for achieving health and nutrition targets, while also recognizing its broader impact on additional goals, such as those related to food security, climate and gender equality. Without high rates of breastfeeding, food security for infants and young children is not possible.[181] [182]

GLOBAL POLICY LANDSCAPE FOR WET NURSING AND RELATED PRACTICES

Legislation and policies on donor human milk and wet nursing can enable appropriate IYCF-E responses. However, many countries do not have clear national legislation, regulations and guidelines to protect and support these practices, especially during emergencies.[183] This is particularly true for wet nursing.

While certain forms of wet nursing, such as foster nursing, are regulated in some settings,[184] regulations and guidance on wet nursing in general are lacking globally.[185] [186] [lxiii] Historical regulations typically focused on commercial wet nursing[187] and are therefore unsuitable for altruistic wet nursing programs that support the rights and well-being of women and children.

Established and widely accepted guidance from health authorities exists for human milk banking and the use of formal donor human milk in clinical settings. Various policy and position statements on informal milk sharing and (less frequently) wet nursing have been issued by breastfeeding support organizations, health ministries and agencies, religious entities and professional organizations, but consensus is lacking. There is a pressing need for cohesive, evidence-based policies and guidelines that can protect, promote and support appropriate wet nursing practices that support the human rights of women and children especially during times of crisis *(see Box 5.2).*

POLICY BARRIERS TO WET NURSING

Legal, regulatory, and administrative barriers can prevent or hinder wet nursing. Key challenges include:

- **Lack of regulatory clarity and evidence-based guidelines**: A lack of clear recommendations, policies and guidelines compromise health workers' ability to support caregivers in making decisions[188] and creates uncertainties and liability concerns for individuals or organizations resulting in unnecessary avoidance of wet nursing.[189] Hesitancy by policy-makers to endorse and provide clear directives on wet nursing can prevent its inclusion in emergency preparedness and response plans and creates gaps that can be exploited through aggressive marketing by the infant formula industry during emergencies.

- **Inappropriate policies and guidelines**: Policies may not be evidence-based or they may be inappropriate for other reasons. For example, wet nursing policies may rely on evidence or guidance milk banking for hospitalized, premature infants, which are not relevant to wet nursing in a community setting.[190] Policies that require overly stringent or invasive screening and testing protocols may be impossible to implement or deter individuals from volunteering as wet nurses. Policies may not appropriately weigh the risks of an infant being wet nursed against the risk of sickness and death in an emergency. Outright prohibitions on wet nursing or public health risk messages are likely to result in wet nursing continuing in secret. This presents missed opportunities to educate communities in life-saving wet nursing, as part of IYCF, and de-stigmatize mothers and wet nurses.[191] [192] [193] Instead, health authorities should provide frontline workers and caregivers with guidance on risk management.[194]

- **Lack of breastfeeding protections:** In many contexts, poor social protection policies create an environment where women might find it logistically and economically challenging to participate in wet nursing. Aggressive BMS marketing and BMS donations during emergencies can undermine breastfeeding practices, including wet nursing.

Overcoming these barriers requires a concerted effort to create clarity and consistency in wet nursing policies that are grounded in evidence and aligned with global recommendations. Policies should also be culturally sensitive, practical and uphold the rights and safety of all involved. The next section offers guidance on achieving this.

[lxiii] An analysis by Gribble et al. (2023) of COVID-19 clinical guidance for maternal and newborn care across 101 countries found that, despite WHO's recommendation for breastfeeding as a standard of care, it was widely undermined. Wet nursing, in particular, was the least adopted of WHO's breastfeeding recommendations, with just 5 per cent of guidelines (1 in 20) recommending it, while the remainder failed to mention it.

B. NATIONAL POLICY AND GUIDELINES

INTEGRATING WET NURSING INTO NATIONAL POLICIES AND GUIDELINES

Governments are responsible for developing, implementing, monitoring, and evaluating national policies on IYCF, IYCF-E and other maternal, newborn and child health related guidelines depending on the context.[195] [196] Policies, and their related strategies, guidelines and action plans, can include wet nursing and related practices as appropriate. IYCF-E policy and guidance documents, including joint statements issued at the start of an emergency, should recommend wet nursing for where maternal breastfeeding is not possible or is insufficient. If required, noting any specific contexts or circumstances where it may not be inappropriate unless a critical analysis of current acceptability and feasibility, confirmed by local experts, indicates otherwise.[197] These actions help to ensure that wet nursing is recognized and supported as a recommended practice, in line with the Sphere Minimum Standards for Humanitarian Action and the Global Strategy for IYCF. *(IYCF standard 4.2).*

Box 5.1: Key considerations for decision-making on remuneration and financial support of wet nurses during emergencies

This guidance addresses wet nursing as a compassionate, consensual and unwaged arrangement, aligning with the World Health Assembly's emphasis on the importance of altruistic, voluntary, non-remunerated donations to ensure the safety and quality of medical products of human origin.[198] In the context of wet nursing, this approach aims to protect wet nurses from exploitation, maintaining that while they should not profit from their voluntary services, they also should not incur any financial or other losses.[199] It includes covering reasonable costs (**compensation**) associated with wet nursing, such as transportation, without offering direct payment for the act of wet nursing itself (known as **remuneration**). Potential costs borne by wet nurses include increased nutritional needs, potential lost income and reduced autonomy.[200] It is important to acknowledge the often overlooked and undervalued value of women's unpaid care work, which includes breastfeeding.

In addition to covering reasonable expenses, particularly during emergencies, consider supporting wet nurses through non-financial means to facilitate wet nursing arrangements and maximise the likelihood of sustained success. Such support can include ensuring access to necessary resources like transportation and communication, as well as food assistance to meet wet nurses' increased nutritional requirements. Non-financial support should aim to alleviate any additional burdens faced by wet nurses, while ensuring it is not disproportionately relied upon or exploited. Care must be taken to integrate these supports sensitively, aligning them with broader humanitarian assistance programmes serving pregnant and breastfeeding women. It is important to acknowledge the often overlooked and undervalued value of women's unpaid care work, which includes breastfeeding.

Introducing financial incentives or other forms of remuneration for wet nurses raises complex ethical considerations and potential risks. Historical examples serve as a cautionary reminder of the harm that can arise from monetizing wet nursing.

Potential risks:

- **Commodification of breastmilk:** The commodification of breastmilk brings significant ethical questions, as it changes milk donation from an altruistic act into a tradable good, prioritizing profit over infant health and well-being.[201] The process of assigning market value to breastmilk risks exacerbating existing social and gender-based economic inequities, potentially exploiting poor populations who may feel compelled to sell their milk for financial gain.[202]
- **Risk of exploitation:** The monetization of breastmilk can have significant risks of exploitation, particularly for economically disadvantaged women who may feel the pressure to become wet nurses for financial gain.[203]
- **Exacerbating inequity:** When breastfeeding or breastmilk is commodified and financial incentives are engaged, there is a significant risk that access to breastmilk could become stratified based on the ability to pay.[204] In a system where breastmilk is primarily accessible through financial transactions, wealthier families or health care institutions may secure more of the available supply, potentially leaving low-income families without access to this potential lifeline. There are also risks to nurslings if wet nurses breastfeed multiple infants to maximize financial gain, including the tendency to prioritize profit over care.

Key ethical considerations when remunerating wet nurses: Policy-makers can help ensure wet nursing practice is ethical and in line with public health goals. This includes maintaining the altruistic basis, ensuring wet nursing is made available based on need and not financial capacity, preventing the exploitation of economically vulnerable women, preventing coercion by others (e.g., family members) to gain access to financial incentives, and prioritizing the autonomy and informed consent of prospective wet nurses.

Government and organizational policies and guidelines should be designed to not only enable, but also actively protect, promote and support wet nursing as a safeguard for infants who cannot be breastfed or cannot be fully breastfed by their own mothers, especially in emergencies.[lxiv] In both emergency- and non-emergency contexts, policies can address:

- Target population
- Roles and responsibilities
- Actions and decision-making
- Screening protocols
- Risk mitigation strategies
- Support systems and services
- Multisectoral integration
- Wet nurse support and compensation
- Education and training
- Monitoring and evaluation
- Legal and ethical considerations[205]
- Rights
- Safeguarding against coercion and exploitation
- Sociocultural and gender considerations, and community engagement
- Emergency-specific solutions, including acceptable compromises and adaptations.
- Minimum standards, evidence base, potential outcomes and intended impact of the policy.

Policy impact assessment: Policies should be regularly reviewed to evaluate impact on the health and rights of wet nurses, any of their own children, and the infants they support to ensure relevance and effectiveness in various circumstances.

FURTHER ACTIONS FOR CREATING AN ENABLING ENVIRONMENT FOR WET NURSING

Wet nursing programmes are less likely to succeed in communities with low breastfeeding rates. Investing in policies and routine programmes that protect, promote and support breastfeeding is a crucial element of emergency preparedness. This should include legislative actions to fully adopt, implement, monitor and enforce the International Code of Marketing of Breast-milk Substitutes to uphold the rights of women and children and to protect breastfeeding, across all contexts.

Box 5.2: Human rights

Women and children both have human rights in relation to breastfeeding.[206] [207] Women's rights include the right to environments that are supportive of breastfeeding, skilled support for breastfeeding (including relactation), the right to control their breastmilk, to be protected from harmful interference by non-State actors.[208]

Infants have a right to support for alternative feeding methods and to achieve the "highest attainable standard of physical and mental health", which can be best achieved through breastfeeding.[209] Introducing policies that facilitate wet nursing where there are willing women and infants that need it can help meet States' human rights obligations to children.[210] Governments must commit to improving the wider cultural, political, economic and institutional factors that make breastfeeding (including wet nursing) possible. Wet nursing policies and programmes must uphold Indigenous peoples' rights, including their traditional knowledge and cultural practices related to collective childcare, in accordance with the *United Nations Declaration on the Rights of Indigenous Peoples.*

It also includes the adoption of evidence-based approaches to improve breastfeeding outcomes, such as the Baby-Friendly Hospital Initiative and community-based peer counselling.[211] Emergency preparedness plans and policies must include adequate provisions for breastfeeding, and skilled breastfeeding support should be part of the minimum package of humanitarian health and nutrition services.[212]

C. DECISION-MAKING: CONSIDERATIONS FOR SUPPORTING/ RECOMMENDING WET NURSING AT SCALE (AT POLICY AND PROGRAMME LEVELS)

Emergency responders should be aware that wet nursing occurs in most communities worldwide and may become more prevalent during emergencies; and as such, they should be prepared to support wet nursing and respond appropriately. At the individual level, trained emergency health and nutrition workers, such as IYCF counsellors, may support informed decision-making about wet nursing, and can play an important role in normalizing and promoting it. At a minimum, policies and guidelines should instruct responders to avoid interfering with or discouraging existing practices when encountered, unless there is compelling evidence to justify context-specific recommendations against wet nursing.

lxiv Policies should be developed in preparedness. If existing policy guidance is absent, outdated or does not adequately address the context at the onset of an emergency, rapid updates or the development of 'stop-gap' guidance may be necessary, as described in the OG-IFE, 2017.

Informed by contextual analysis and assessment of feasibility and acceptability, policy-makers and decision-makers need to determine the extent to which wet nursing will be actively protected, promoted and supported in a given context. Considerations to inform decision-making at the policy and programmatic levels are covered below.

BROADER BENEFITS OF SUPPORTING WET NURSING AT SCALE

As described in Chapter 1B, wet nursing confers on infants many of the same protections as maternal breastfeeding and, in most situations, is a safer and more beneficial infant feeding option than BMS, especially in emergencies. Wet nursing not only directly saves lives, but when supported at scale in policy and practice, it can also:

- **Strengthen breastfeeding advocacy** by increasing awareness of the value of breastfeeding, normalizing breastfeeding and reducing associated stigmas, and improving overall community breastfeeding rates.
- **Build community resilience**, given that established wet nursing practices contribute to the development of a resilient community culture of mutual aid and self-reliance. They also reduce dependency on BMS and external humanitarian assistance in the form of costly BMS interventions that pose significant risks.
- **Enhance mental health and psychosocial well-being** by fostering nurturing care and a sense of community care and connectedness, as well as maternal identity and solidarity. On an individual level, the breastfeeding hormones improve infant and maternal mental health and supports healthy attachment development for maternal orphans.
- **Empower women** by highlighting the critical role that they play in infant nutrition and overall community health.

CONTEXTS WHERE SUPPORTING WET NURSING AT SCALE MAY NOT BE RECOMMENDED

When developing policies to support wet nursing, especially in emergency contexts, it is important to identify specific contexts and scenarios where the recommendation to support wet nursing at scale may *not* be appropriate or feasible. These include:

- **Some infectious disease outbreak contexts, with adequate evidence to justify temporary avoidance of breastfeeding.**[213] These include outbreaks of a small number of contagious infectious diseases recommended by WHO in case of infection and/or exposure. An example of this is Ebola virus disease, for which wet nursing is not recommended given the proven high risk of severe illness and death and the high risk of transmission between a wet nurse and an infant if either becomes infected.[214] In the event of an infectious disease outbreak, consult WHO on infant feeding recommendations and ensure that appropriate, evidence-based infant feeding recommendations are in place for breastfeeding mothers and wet nurses.[lxv] In the absence of quality evidence, breastfeeding, including wet nursing, should continue to be recommended, particularly early in disease epidemics.[215]

  As per global guidance, these exceptional contexts do not include high HIV prevalence contexts, even if HIV testing is not available during an emergency.
- **Scenarios where emergency response capacity is limited.** Where overall emergency response capacity is constrained or humanitarian access is limited, it may not be feasible for programmes to actively initiate and facilitate wet nursing arrangements. Until response capacity is strengthened, the priority should be to support, respect and protect existing community-led wet nursing practices, ensuring they are not stigmatized or undermined by emergency responders, especially in environments with high prevalence of gender-based violence/intimate partner violence and serious safety concerns for women.

CONTEXTS WITH SOCIOCULTURAL BARRIERS TO WET NURSING

Sociocultural barriers to wet nursing, such as wet nursing being unfamiliar or undervalued due to the ready availability of BMS, viewed negatively due to past harmful practices, or discouraged by religious or cultural beliefs, should not be considered to contraindicate a wet nursing program. Rather, where such barriers exist, respectful and culturally sensitive IYCF counselling and community consultation (including with religious and community leaders) should be undertaken in order to determine feasibility. It should be noted that emergencies may influence acceptability of wet nursing, and wet nursing should not be dismissed on the basis of lack of acceptability outside of the pre-emergency context. In Muslim communities, milk kinship should be appropriately considered. At an individual level, it remains important for providers to enable individuals to make their own decisions from the available feeding options, recognising the diversity that exists among individuals within cultures and religions.

lxv For further guidance, see: IFE Core Group, Infant feeding during infectious disease outbreaks: a guide for policy makers 2021. If WHO does not have infant feeding recommendations for a new or emerging infectious disease, national interim feeding recommendations will need to be developed based on the best available evidence.

ANNEX A: DEFINITIONS OF TERMS

Antiretroviral drug	The medicine used to treat HIV infection.
Antiretroviral therapy	The medical treatment regimen for people living with HIV, which includes one or more of the medicines used to treat HIV infection, known as antiretroviral drugs.
Artificial feeding	Feeding with breastmilk substitutes.
Counselling	An interaction between a trained provider and a counselling client – usually a mother, other caregiver, wet nurse or pregnant woman – with the purpose of providing practical support and instilling the skills and confidence needed to feed and care for infants and young children as recommended. Counselling interactions also aim to help counselling clients make informed decisions on what is best for themselves and an infant or young child in their situation. Counselling is different from education or messaging in that it involves a two-way communication and interaction.
Cup feeding	Feeding from an open cup without a lid, whatever is in the cup.
Breastfeeding	The practice of a woman providing breastmilk directly from her breast to an infant or child.
Breastmilk	Milk produced by human mammary glands. Also known as *human milk.*
Breastmilk feeding	The feeding of expressed breastmilk to an infant. `
Breastmilk substitute	Any food or drink marketed or otherwise represented as a partial or total replacement for breastmilk, including infant formula, follow-up formula and growing-up milks, and other milk products, foods and beverages, including bottle-fed complementary foods.
Donor human milk	Expressed breastmilk voluntarily provided by a lactating woman to feed a child other than her own. *Informal donor human* milk is fresh or frozen expressed breastmilk that is provided by a lactating woman to feed a child that is not her own, outside of formal milk banking systems, through a practice known as expressed *breastmilk sharing, informal milk sharing,* or *peer-to-peer or private-arrangement milk sharing. Formal donor human milk* is sourced from a human milk bank (see definition below) to breastmilk-feed a child with screened and processed expressed breastmilk.
Emergency	An event or series of events that represents a critical threat to the health, safety, security or well-being of a community or other large group of people. Emergencies can be natural disasters or human-made crises, sudden or slow onset, short-term or protracted. Emergencies are humanitarian crises if international support (humanitarian assistance) is required to meet the basic needs of a population.
Exclusive breastfeeding	When an infant receives only breastmilk directly from the breast and no other liquids or solids, including water (with the exception of prescribed vitamins, minerals or medicines).
Expressed breastmilk	Breastmilk that is removed from the breast by hand or pump before it is fed to an infant.
Frontline worker	Emergency/humanitarian responder who interacts directly with the emergency-affected population. Examples include IYCF counsellors, community health workers, midwives, nurses, child protection case workers, hygiene promoters and distribution staff.
Full assessment	A systematic way for trained IYCF counsellors to gain an in-depth understanding of the feeding practices of a child under 2 years of age to assess and analyse the type of support needed. The full assessment commonly follows the simple rapid assessment.
HIV-free child survival	Refers to strategies and practices aimed at ensuring that children born to mothers living with HIV remain HIV-negative and survive childhood.
HIV risk assessment	A process (usually a set of questions) that provides insight into the likelihood that a prospective wet nurse has been exposed to HIV.

HIV-exposed infant/ child	An infant or child born to a mother living with HIV, until that child is reliably excluded from being infected with HIV.
Human milk bank	A service that collects, processes, stores and distributes expressed breastmilk from donating mothers to infants who need it. Their operations include recruitment, screening and testing of donors and, typically, pasteurizing and testing of donor milk.
Induced lactation	The stimulation of breastmilk production in a woman who has not previously lactated.
Infant	A child aged 0–11 completed months (may be referred to as 0 to <12 months or 0 to <1 year of age). An older infant refers to a child from the age of 6 months up to 11 completed months of age (late infancy). *Note that the term "infant" is used throughout the guidance for brevity. However, this guidance applies to both infants and young children, unless specified otherwise.*
Informed consent	Ensuring someone understands and agrees to participate in a procedure or process after receiving all necessary information and answers to any questions. It requires that the person is free to make an intentional and voluntary decision, which may include refusal.
Lactation	The production and secretion of breastmilk by the mammary glands.
Nursling	For the purposes of this guidance, an infant or young child who is breastfed by a wet nurse.
Non-breastfed	A child who does not receive any breastmilk.
Primary caregiver	A child's primary caregiver is the person who provides most of a child's daily needs, including emotional, physical and developmental support. Primary caregivers may be mothers, fathers (including adoptive and foster parents), grandparents or other family members acting as the child's main source of care and protection. In some cases, primary caregivers care for children in institutional settings, such as orphanages or within emergency services, such as Ebola treatment centre nurseries. *Note that the short form "caregiver" is used throughout the guidance for brevity.*
Safeguarding	Measures and policies implemented to protect individuals, especially children, from abuse and maltreatment and to ensure their welfare and safety.
Screening test	Medical tests or procedures conducted on prospective wet nurses and nurslings to detect health conditions, infectious diseases or other factors that could pose a risk during wet nursing.
Skilled support	Provision of technical assistance by a qualified health or nutrition worker to a caregiver experiencing difficulties with breastfeeding, complementary feeding or artificial feeding.
Psychological first aid	First-line emotional and practical support for someone experiencing acute distress following a recent (large-scale or individual) crisis event. Psychological first aid key action principles are to *look, listen* and *link* as part of a humane and supportive response.[216]
Responsive breastfeeding	Breastfeeding a baby in response to signs of readiness to feed, as frequently and for as long as the baby wants, from one or both breasts at each feed, without specific regulations. Also known as *unrestricted* or *on-demand* feeding.
Relactation	The resumption of breastmilk production (lactation) in a woman who has stopped lactating, recently or in the past, to breastfeed her own or another infant, even without a further pregnancy.
Risk	The potential for loss, harm or any other negative occurrence. An expression of the probability that exposure to a hazard will cause harm, considering exposure (contact with a hazard) and vulnerability (ability to be harmed by a hazard.
Risk mitigation	Strategies and actions taken to minimize exposure to a hazard or reduce vulnerability.
Simple rapid assessment	A simple screening tool that does not require training in IYCF and is used to rapidly prioritize mothers or other caregivers for full assessment and further counselling.

Shared decision-making	A joint process in which a service provider, such as an IYCF counsellor or health worker, works together with a person to reach a decision about the infant regarding feeding and care. It involves choosing tests and treatments based both on evidence and on the person's individual preferences, beliefs and values. It makes sure the person understands the risks, benefits and possible consequences of different options through discussion and information sharing.[217]
The Code	Refers to the International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions, aimed at protecting and promoting breastfeeding by restricting the marketing of breastmilk substitutes, feeding bottles and teats.
Trauma-informed care	A framework that guides IYCF counsellors' support of caregivers that is sensitive to a trauma's ongoing impact and seeks to avoid activating post-traumatic responses or causing further trauma.
Young child	In the context of IYCF-E programming, a child aged 12–23 completed months (may be referred to as 12 to <24 months or 1 to <2 years of age).

ANNEX B: WET NURSING TERMINOLOGY AND ALTERNATIVE BREASTFEEDING PRACTICES

Adoptive breastfeeding	The act of a mother breastfeeding a child who she has adopted.
Co-feeding	The practice of a child being breastfed by more than one caregiver, such as by co-wives in a polygamous household.
Cross feeding	The practice of a child being breastfed by his or her mother as well as a woman other than the mother, as part of an informal, non-monetary arrangement. This arrangement can be reciprocal, where each mother breastfeeds both her own and the other's child, or one-way. It is a form of wet nursing which may be used to support relactation. Also known as *cross breastfeeding, cross nursing* and *shared breastfeeding*.
Grandmother breastfeeding	The practice of a grandmother breastfeeding her grandchild, serving as a form of wet nursing.
Foster breastfeeding	The act of a foster mother breastfeeding a child who is temporarily in her care.
Milk kinship	A cultural family bond that is established through the breastfeeding of an infant by a wet nurse. This bond extends to the wet nurse, the infant(s) she breastfeeds, and their relatives (kin). *Milk siblings* are individuals who, though not biologically related, were breastfed by the same woman and are considered to be each other's milk brother or sister through this milk kinship.
Milk mother	An alternative term for wet nurse, emphasizing the nurturing aspect of breastfeeding. In certain cultures, this role may establish a milk kinship bond, while in other contexts, it simply refers to the act of providing nurturing care through breastfeeding, irrespective of familial or kinship implications.
Wet nursing (verb)	The practice of a woman breastfeeding someone else's child. Also known as *non-maternal breastfeeding, allomaternal breastfeeding* and *at-the-breast milk sharing.*
Wet nurse (noun)	A woman who breastfeeds a child who is not her own. Also known as a *milk mother.*

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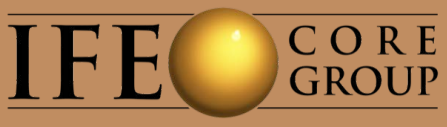
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